PREA AUDIT REPORT ☐ INTERIM ☒ FINAL

JUVENILE FACILITIES

Date of report: December 07, 2017

Auditor Information			
Auditor name: Allen Wallace			
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Telephone number: 512-963-8763			
Date of facility visit: May 9-11, 2017			
Facility Information			
Facility name: Evins Regional Juvenile Center			
Facility physical address: 3801 E. Monte Cristo Rd. Edinburg Texas 78541			
Facility mailing address: *(if different from above)*			
Facility telephone number: 956-289-5500			
The facility is:	☐ Federal	☒ State	☐ County
	☐ Military	☐ Municipal	☐ Private for profit
	☐ Private not for profit		
Facility type:	☒ Correctional	☐ Detention	☐ Other
Name of facility's Chief Executive Officer: Tamu Steptoe			
Number of staff assigned to the facility in the last 12 months: 105			
Designed facility capacity: 176			
Current population of facility: 136			
Facility security levels/inmate custody levels: High			
Age range of the population: 10-19			
Name of PREA Compliance Manager: Felix Garza		**Title:** Program Specialist/Compliance Officer	
Email address: felix.garza@tjjd.texas.gov		**Telephone number:** 956-289-5500x 5306	
Agency Information			
Name of agency: Texas Juvenile Justice Department			
Governing authority or parent agency: *(if applicable)* Click here to enter text.			
Physical address: 11209 Metric Blvd., Bldg. H, Suite A, Austin, Texas 78758			
Mailing address: *(if different from above)* Click here to enter text.			
Telephone number: 512-490-7130			
Agency Chief Executive Officer			
Name: David Reilly		**Title:** Executive Director	
Email address: david.reilly@tjjd.texas.gov		**Telephone number:** 512-490-7004	
Agency-Wide PREA Coordinator			
Name: Jerome Williams		**Title:** Director of PREA Compliance Department	
Email address: jerome.williams@tjjd.texas.gov		**Telephone number:** 512-490-7671	

AUDIT FINDINGS

NARRATIVE

Introduction

The Prison Rape Elimination Act (PREA) on-site audit of Evins Regional Juvenile Center (ERJC) was conducted on May 9-11, 2017. This was the second audit of the facility; the first occurred on August 4-5, 2014 during which time the facility became fully PREA compliant after implementing three corrective actions. ERJC is a Texas Juvenile Justice Department (TJJD) facility located in Edinburg, Texas. The audit was conducted by Allen Wallace and Dwight Sadler, U.S. Department of Justice Certified PREA auditors and assisted by Lisa Hale (Certified PREA Auditor) and Emily Childs(Assistant). Ms. Hale and Ms. Childs assisted with formal interviews of youth and staff. Youth and staff interviews were conducted on the first and second day of the audit. Interviews were conducted in private offices on dorm 1, which is utilized as additional office space. ERJC staff members walked youth to and from the interviews, and the staff members were interviewed according to the schedule developed by the Compliance Officer.

Supervisory staff accompanied the auditors (Mr. Wallace and Mr. Sadler) during a facility inspection of all campus buildings located inside the secure fence on the second day of the audit, and informal interviews were conducted with youth and staff during this process. Also on the second and third day, auditors completed interviews and on-site documentation review. The Compliance Officer organized the additional documentation by each standard in a portable file cabinet, which was provided to the auditors for the duration of the audit.

Pre-Audit

Pre-audit preparation included sending the PREA audit notification to the facility Compliance Officer and verifying the notices were posted at least six weeks prior to the audit and included necessary contact information. The Compliance Officer provided time-stamped photographs of the notices throughout the facility, which confirmed they were posted on brightly colored paper, at least six weeks prior to the audit, and contained the required information. The Pre-Audit Questionnaire (PAQ), TJJD policies, TJJD and facility procedures, and documentation supporting compliance with each standard were uploaded to a secure agency drive. The auditors reviewed the PAQ, policies, and other documents including organizational charts, mission statement, protocols, staffing plans, various contracts, and training curricula specific to each standard. Questions and requests for clarification and additional information were listed in the comments section by standard in a Compliance Tool. The auditors sent the tool via email to the facility Compliance Officer and the TJJD PREA Compliance Director. Responses were typed within the document, returned, and reviewed by the auditors. Follow-up phone calls were exchanged to gain further clarification and to discuss the audit process. A list of all staff members including those with the following specialized designations: administrators, supervisory staff, medical and mental health staff, first responders, human resources staff, SAFE/SANE staff, volunteers and contractors, intake staff, incident review team members, monitors of retaliation, investigative staff, and staff responsible for supervising youth in isolation was provided to the auditors. A list of current youth at the facility was also provided and organized into each of the National PREA Resource Center's prescribed targeted populations: youth who reported a sexual abuse, are limited English proficient, have a disability, those placed in isolation, disclosed prior sexual victimization during the risk screening, or who identify as lesbian, gay, bisexual, transgender, or intersex (LGBTI). From these lists, the auditors randomly selected staff members and youth to be interviewed. The auditors requested the initial and annual criminal background check history of ten (10) randomly selected ERJC employees representing different levels of seniority, authority, and length of employment from the TJJD Human Resources Administrator. Four additional personnel files were reviewed on site to determine compliance with criminal background checks, reference checks, and Child Abuse Registry checks. To verify employees, volunteers, medical and mental

health care staff, and one (1) contractor received and acknowledged understanding PREA-specific training, the auditors reviewed Sign-In and Acknowledgment Forms from the previous year for New Hire, Annual, and facility Town Hall trainings.

On-Site

Upon arriving the auditors met with the facility Superintendent, Assistant Superintendent, and Compliance Officer to further discuss the on-site portion of the audit and facility inspection methodology. As previously stated formal resident and staff interviews were conducted on the first day of the audit. The auditors randomly selected and compiled a list of 18 Juvenile Correctional Officers (JCOs), 16 additional staff members and selected 26 youth prior to the audit for formal interviews. The list was sent via email to the PREA Compliance Officer the day before the on-site portion of the audit to ensure independent responses. The auditors interviewed correctional, supervisory, and specialized staff representing different levels of seniority and authority assigned to all three shifts, medical and mental health care staff, agency and facility department heads, and youth from all dorms representing each category of the PREA Resource Center's (PRC) targeted populations. Two volunteers were also interviewed by telephone to discuss the PREA training they received. The Agency PREA Coordinator, Executive Director, Human Resources Director, and Manager of Youth Services Contracts were interviewed in the TJJD Central Office prior to the on-site portion of the audit.

The Compliance Officer and a Manager I accompanied the auditors during the walkthrough of all buildings within the security fence including administration, training, dorms, offices, interior and exterior mechanical/ storage closets, education, cafeteria, warehouse and the gym. During the inspection, consideration was given to camera placements and potential blind spots, the configuration of living units and restroom and shower areas, programming activities and educational programs, the level of youth supervision, indicators of any area lacking sufficient monitoring, and PREA notifications and posters. Throughout the inspection, brief informal interviews were conducted with staff members and youth in the security units, education building, the infirmary, and in dorms. On the second evening of the audit the auditors also observed dorms 3 and 4 evening routine that included personal hygiene time and showers.

The interviewers used the National PREA Resource Center's Interview Protocols for Juvenile Facilities for guidelines and interview questions. Responses to questions regarding staff members' knowledge of PREA policies, reporting responsibilities, first responder and investigative duties, and training were compiled and integral to determining PREA compliance. Youth responses to questions regarding their knowledge of PREA policies, the education and services they receive, and intake process were also essential in determining compliance. During interviews, a mental health professional was available to provide services should youth need assistance after an interview. This service was not utilized during the interview portion of the audit.

The second and third day of the on-site portion involved reviewing additional documentation for each standard provided by the Compliance Officer and requested by the auditors. Thirteen (13) resident files were randomly selected to audit and were reviewed on site to determine compliance with intake procedures, safe housing determinations, PREA comprehensive education, and disclosures of prior victimization. Each youth file included an initial health screening, photograph, body identification form, family history, educational information, prior commitments, intake assessments, and psychological evaluations and notes. All youth participate in these assessments/ reassessments upon placement. No youth reported a prior sexual abuse, therefore the required follow-up within 14 days was not evident.
Four (4) additional personnel files for random staff members and a staff member who was recently promoted were reviewed to determine background reviews, disclosure of PREA standards violations, Child Abuse Registry Checks, and reference checks. Training records for seven (7) volunteers were also reviewed for evidence of PREA training.

On the third day, the auditors conducted a brief exit meeting to discuss overall PREA compliance, staff and

youth knowledge of the PREA, and actions to be taken following the on-site portion with the TJJD PREA Compliance Director, facility Compliance Officer, Superintendent, and Assistant Superintendent.

An Interim PREA Audit Report indicating the compliance determinations for each standard sent via email to the facility Superintendent, PREA Compliance Officer and PREA Compliance Director on June 24 2017. Corrective action was requested for each unmet standard.

DESCRIPTION OF FACILITY CHARACTERISTICS

The ERJC is a high-restriction facility in Edinburg, Texas that serves adolescent males between the ages of 10 and 19 during an average length of stay of 9 -12 months. Treatment programs includes Violent Offender Program, Aggression Replacement Training (A.R.T.), Sexual Behavior Treatment Program, Mental Health Treatment Program, and Alcohol and Other Drug Treatment.

Entry and exit from the facility is controlled by a secure gatehouse and vehicle sallyport. The facility has a single perimeter secure fence. There are 15 buildings within the fenced portion of the campus including administration, training, 1 building serving as the infirmary and social services, a cafeteria/warehouse in one structure, vocational, greenhouse and 2 educational buildings, gymnasium, recreation building, security unit, 3 housing dorms, and 1 dorm used as additional office space and special activities. All housing units are single cell / room design. No new construction was reported during the previous 12 months. The facility could house up to 176 residents, although the current budgeted population is 136.

Youth receive on-site medical services from the University of Texas Medical Branch (UTMB) clinic and year-round education through TJJD where they may earn their diploma or high school equivalency certification or take college classes. Dorms share common day rooms and showers and contain staff offices, laundry areas, and storage closets. The facility was 81 registered volunteers and 1 contractor who may have contact with youth. The Administrative Investigations Division (AID) and the Office of the Inspector General (OIG) conduct administrative and criminal investigations in-house. The Incident Reporting Center (IRC) is maintained by the OIG for the purpose of reporting information concerning abuse, neglect, and exploitation. Youth and staff may make reports by calling the IRC or the Office of the Independent Ombudsman or by utilizing the facility grievance system.
Sexual Assault Medical Exams are conducted off site at Doctor's Hospital at Renaissance in Edinburg, Texas.

SUMMARY OF AUDIT FINDINGS

The Interim PREA Audit Report findings include 28 standards in compliance, 12 standards in noncompliance, and 1 standard exceeding compliance.

The facility's prevention efforts include a zero-tolerance of sexual abuse and harassment evidenced by policy, documentation, and interviews; the education of youth regarding the policy; requirements of contracted entities to adhere to the same zero tolerance; staffing plans intended to protect youth against sexual abuse; and disallowing or limiting cross-gender viewing. ERJC supervisory staff members conduct unannounced rounds twice per month for each of three shifts. An extensive video monitoring system with cameras located throughout the interior and exterior of all buildings augments the zero-tolerance efforts. Survillance cameras were viewed on the two large housing units and the security unit to confirm the system was operational. During the walk through of the kitchen/cafeteria it was noted additional cameras could be placed in the pantry area to enhance the monitoring capability. Interviews with staff and youth indicated they had received training and information regarding the right to be free from sexual abuse and harassment and all described multiple ways to report allegations. Staff members provided inconsistent responses regarding cross-gender pat down searches. It was also noted some staff were unsure of the difference between "cross-gender" and "transgender" pat searches as they used the terms interchangeably.

Evidence of responsive planning includes providing youth with SAFE/SANE services, policy and procedures regarding investigations, and the training of investigators to obtain usable physical evidence. No forensic medical examinations have been necessary, but facility protocol stipulates that youth requiring the examination would be transported to a local medical center. The number of administrative and criminal investigations of sexual abuse and harassment allegations reported for ERJC (AID, and OIG PAQs) differ. The number of investigations and notifications at the conclusion of the investigation were also inconsistent. These discrepancies are addressed per standard below. Interviews and training records of investigators, facility staff members, and youth indicate ERJC has received relevant training. However Volunteer training records did not indicate any further training past the initial training received regarding PREA requirements. This review also indicated one (1) older volunteer (prior to 2011) had no documented training on PREA.

Training and education efforts include the development of training curricula, annual staff training, campus meetings, and dorm meetings addressing PREA-specific topics. Youth PREA education occurs during intake at the Ron Jackson State Juvenile Correctional Complex - O&A unit, and then once again upon their arrival at the ERJC. Interviews with youth indicated PREA education is provided upon their arrival at Evins. Although, during interviews youth were not aware of the availibilty of outside counseling-support services. They also were unable to identify the Office of Independent Ombudsman as a secondary- third party reporting ssource. Zero Tolerance posters in Spanish and English are displayed throughout the campus and PREA-related information is included in the Youth Handbook. During interviews, staff members said they had received PREA training during new-hire and annual trainings.

An objective screening instrument is used along with psychological assessments to determine housing and room assignments. Subsequent housing decisions are determined by the agency's safe housing assessments. TJJD policy requires re-assessments be conducted on a routine basis or as a result of a significant event. The re-assessment instrument does not ask the same specific questions as the initial assessment instrument.

The TJJD's policies align with the PREA Standards regarding the reporting, responses, and immediate actions following a report of sexual abuse. The facility develops a written institutional plan to coordinate responses to allegations of sexual abuse. The plan includes procedures for specific staff members and the actions each must take. The TJJD policies and coordinated response contained in the written plan appear to contradict the duties of first responders, and the identification of a first responder. It was also suggested that the facility plan be dated and revision dates be noted on the plan. However, staff members demonstrated an overall

knowledge of first responder duties during interviews.

The TJJD AID conducts in-house administrative investigations and the OIG conducts criminal investigations. One investigator from each division was interviewed and demonstrated compliance with each PREA Standard involving investigations, collection of evidence, notifications, referring for prosecution, and actions taken following an investigation. There was discrepancy in the total number of allegations, investigations, and notifications reported by the facility, AID, and OIG. The number of required notification letters to victims and / or families were also inconsistent with the number of investigations reported.

The Interim Audit Report was sent to Evins on June 24, 2017 with requested corrective action for each noncompliant standard. The facility and PREA Compliance Director began implementing corrective actions prior to receiving the interim report and continued these efforts during the 180-day corrective action period. Throughout this period, additional and revised forms and documentation were reviewed, and communication between the auditor, PREA Compliance Officer, and Compliance Director was maintained. Prior to the conclusion of this period, the auditor conducted a follow-up site visit on June 20,2017 to review additional documentation. On November 16, 2017 an additional on site visit was completed to conduct interviews. An additional 10 Juvenile Correctional Officers (JCO), 2 Case Managers, Facility Trainer, On-the-Job JCO Trainer, the Superintendent, the PREA Compliance Officer, and 7 youth including those with limited reading skills / limited English proficiency and 1 youth identifying as transgender were interviewed. The new training cirriuclum "Gender & Sexuality: A Changing Perspective" (dated 09/01/2017) and the PAT Search training video was reviewed with the training staff. The agency's new Safe Housing Re-Assessment (CCF-36) documentation was also reviewed with the PREA Compliance Officer to insure compliance with the implementation of same. Based on a review of the revised and additional documents and follow-up interviews, the auditor determined that Evins Regional Juvenile Center achieved full compliance with all PREA standards. Details of determinations of compliance for each standard are discussed below.

Number of standards exceeded: 1

Number of standards met: 40

Number of standards not met: 0

Number of standards not applicable: 0

Standard 115.311 Zero tolerance of sexual abuse and sexual harassment; PREA Coordinator

☐ Exceeds Standard (substantially exceeds requirement of standard)

☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Documentation and Policy Reviewed:

1. Completed PAQ
2. GAP 380.9337 (a), (b), (d)(1-2)
3. INS 71.01
4. ERJC and TJJD organizational charts

Interviews:

1. PREA Compliance Director (TJJD Central Office Interview)
2. Compliance Officer

(a): The TJJD General Administrative Policy (GAP) along with the Institution Operations Policy (INS) outline TJJD's written policy mandating zero tolerance of and TJJD's response to sexual abuse, sexual harassment, or sexual activity. The policies contain PREA-related definitions, general provisions, prevention planning, responsive planning, training and education, screening for risk, reporting, responses following a report, investigations, disciplinary sanctions, medical and mental health care, incident reviews, and data collection and storage.

(b): The TJJD has a designated agency-wide PREA Compliance Director as well as facility-level PREA Compliance Officers. The TJJD, Monitoring and Inspections Division, and EJRC Organizational Charts evidence the positions of the PREA Compliance Director and facility Compliance Officer within the agency. The agency PREA Compliance Director reports to the Director of Monitoring and Inspections Division. The ERJC chart shows that the facility Compliance Officer reports to the facility Superintendent. The agency PREA Compliance Director said he has sufficient time and authority to perform his duties and is able to interact with the 14 facility Compliance Managers on a regular basis. The ERJC Compliance Officer said he has sufficient time to perform his duties and is able to work with the management team to make sure new policies are implemented, monitoring efforts are reviewed, and documentation collected and analyzed. If PREA compliance issues are found, he works with the facility leadership to implement changes and ensure compliance.

(c): The TJJD employees an agency PREA Compliance Director as well as a PREA Compliance Officer at each facility. The TJJD, Monitoring and Inspections Division, and ERJC Organizational Charts evidence the positions of the PREA Compliance Director and facility Compliance Officer within the agency. The agency PREA Compliance Director reports to the Director of Monitoring and Inspections Division. The ERJC chart shows that the facility Compliance Officer reports to the facility Superintendent. The primary responsibility of the Compliance Director is to coordinate PREA compliance efforts at each of the TJJD facilities, which

includes six secure facilities and eight halfway houses. The Compliance Officer at the facility is responsible for PREA compliance efforts at their respective facility. ERJC's Compliance Officer coordinates all PREA compliance efforts and stated he had sufficient time and authority to perform these duties, which include working with facility leadership to ensure new policies and practices are implemented and deficiencies corrected.

Corrective Action: None

Standard 115.312 Contracting with other entities for the confinement of residents

- ☐ Exceeds Standard (substantially exceeds requirement of standard)
- ☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does Not Meet Standard (requires corrective action)

Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Documentation and Policy Reviewed:

1. Completed PPAQ
2. GAP 380.9337 (e)
3. Contracts the agency has entered into for the confinement and care of youth
4. Contract Provider: PREA Continued Compliance Monitoring form
5. Multiple Contract Residential Site Visit Forms

Interviews:

1. TJJD Manager of Youth Services Contracts (TJJD Central Office Interview)

(a): The TJJD's policy requires all new or renewed contracts for residential placement to comply with the PREA standards. The TJJD website indicates it contracts with seven entities. Five of these are required to comply with the PREA standards. The other two are foster care/group homes and do not require PREA compliance. The contracts for the facilities required to comply with the PREA include language stating the contractor will "self-monitor" for compliance as well as acknowledge that "TJJD will conduct announced and unannounced compliance monitoring visits." The contract also states the contractor is "responsible for paying for a PREA audit every three years...," and during the "non-audit period, TJJD will perform an audit at no cost to Contractor to ensure continued compliance with the PREA." The contract for one of the facilities that does not require PREA compliance includes language stating that the "Service Provider will be required to provide PREA education to both staff and youth as well as post TJJD zero tolerance posters in common areas of the facility/foster home."

(b): The TJJD requires all of the contracted facilities to comply with the PREA with the exception of the two that are foster care/group home programs. The TJJD's Manager of Youth Services Contracts described her monitoring responsibilities as conducting site visits, observing, and interviewing youth. One PREA Continued Compliance Monitoring form and seven Contract Residential Site Visit forms were reviewed. The monitoring

form includes notes that intake forms, risk screening, staffing plan, and policy were reviewed during the monitoring visit by the Manager of Youth Services Contracts. The site visit forms also include a note stating that PREA posters were observed.

Recommendation: The contract language states that "an audit" will be performed by TJJD at no charge. No evidence of a completed audit during non-audit years was provided. The auditors recommend conducting an audit during non-audit years or revising the language of the contracts.

Corrective Action: None

Standard 115.313 Supervision and monitoring

- ☐ Exceeds Standard (substantially exceeds requirement of standard)
- ☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does Not Meet Standard (requires corrective action)

Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Documentation and Policy Reviewed:

1. Completed PAQ
2. GAP 380.9337 (e)
3. Staffing plans
4. Time-stamped evidence of unannounced rounds
5. Unannounced Visit forms that include the staff member's name, shift, and observation notes
6. Facility ratio reports

Interviews:

1. Superintendent
2. Compliance Officer
3. Staff responsible for conducting unannounced rounds

(a): The TJJD policy requires each facility to develop a written staffing plan that considers staffing levels and patterns, video monitoring, and deviations from the plan. The Superintendent must approve the plan for each living unit with consideration given to each element for Subsection (a) of this standard. The Long-Term and Orientation and Assessment Safe Housing Staffing Plans include supervisory signatures indicating approval. The TJJD Director of State Programs and Facilities provided a memo describing the development process, which includes three phases and the actions taken during each phase. These include conference calls with facility superintendents, in-person meetings, and occasional consultation with finance leadership and the Director of PREA Compliance and a review by the Senior Director of Finance, the Compliance and Accountability Officer, and the Director of State Programs and Facilities. Per the safe housing plans, the Compliance Officer reported reviewing safe housing rosters once per week to compare to each youth's stage, assigned room, and risk level to monitor for discrepancies. This was supported with signed and dated safe

housing dorm census reviews.

Each plan indicates the facility intends to comply with the staff-to-youth ratio of 1:8 during waking hours and 1:16 sleeping hours ratio over time to meet the PREA standard effective October 2017. The current ratio is 1:12.

The Superintendent and Compliance Officer stated each item in this section is considered when updating the facility staffing plan. The Superintendent stated she participates with TJJD Central Office staff in the development process and provides input and justifications regarding staffing needs at ERJC.

(b): The facility and ratio reports and interviews with the Compliance Officer and Superintendent indicate the facility did not deviate from the staffing plan in the past 12 months. TJJD policy states that deviations are only permitted during limited and exigent circumstances and that any deviation and the reason for the deviation must be documented.

(c): TJJD policy requires the facility to maintain a staff-to-youth ratio of 1:12 during youth waking hours and 1:16 during youth sleeping hours. Only security staff members are included in the ratio. ERJC considers any staff member who has completed Juvenile Correctional Officer training a security staff member. The Superintendent stated that the facility plans to comply with the 1:8/1:16 ratios over time through shift realignments, additional full-time employees, and population considerations. These revisions will be included in an updated staffing plan.

(d): Safe housing plans were reviewed for ERJC. Housing plan includes staffing plan procedures, provisions, revisions to the campus schedules and current population, and procedures regarding room and dorm assignments, reassessing for safe housing, PREA supervision requirements, and facility floor plans and camera totals. TJJD policy requires the assessment, determination, and documentation of the consideration of adjustments needed to the staffing plan, staffing patterns, video monitoring, and resources committed to ensure adherence to the staffing plan. The TJJD Director of State Programs and Facilities provided a document describing the development process, which includes three phases and the actions taken during each phase. The Senior Director of Finance, the Compliance and Accountability Officer, and the Director State Programs and Facilities review the plan. The Superintendent, Director of Secure Facility Operations, Senior Director of State Programs and Facilities, and the PREA Compliance Director approve the plan, which is indicated by their signatures. The Superintendent stated she participates with TJJD Central Office staff in the development process and provides input and justifications regarding ERJC staffing needs. The PREA Compliance Director stated he confers with the facility Superintendent and Central Office staff regarding actual and future staffing needs for ERJC.

(e): TJJD policy requires managerial staff members to conduct and document unannounced rounds at least twice per month on each shift. Policy also prohibits staff members from notifying other staff members that unannounced rounds are occurring. The auditors reviewed time-stamped photographs and Unannounced Visit forms that include the staff member's name, shift, and observation notes prior to the audit and additional Unannounced Visits and shift log sheets on site. Documentation indicated unannounced rounds met PREA standard although December 2016 and January 2017 10pm-6am shift lacked one (1) unannounced visit to meet TJJD agency policy. Staff are discouraged from alerting other staff that unannounced visits are occurring and that they varied the times and routine of the rounds so they are unexpected. Random staff members said unannounced rounds occurred regularly during each shift and that they were documented on dorm shift logs. They reported documenting these rounds as they would any occurrence of a person entering or exiting the dorm. A review of shift logs indicated unannounced rounds and entries and exits to and from the dorm are documented.

Recommendation:

1. Ensure all TJJD agency policy requirements for unannounced rounds are conducted and documented.

2. Compliance for this standard was supported by the description of the development process provided by the TJJD Director of State Programs and Facilities and through interviews with the PREA Compliance Director and Superintendent. Although the description of the staffing plan development process includes each of the required elements, the auditors recommend clearly recording discussions or exchanges of information regarding the assessment, determination, and documentation of the consideration of adjustments needed to the staffing plan, staffing patterns, video monitoring, and resources committed to ensure adherence to the staffing plan. Records could include meeting minutes, sign-in sheets, emails, or documentation of phone calls regarding the discussions or participation in the development process.

Corrective Action: None

Standard 115.315 Limits to cross-gender viewing and searches

☐ Exceeds Standard (substantially exceeds requirement of standard)

☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Documentation and Policy Reviewed:

1. Completed PAQ
2. GAP 380.9337 (e)(4)
3. GAP 380.9709 (g)
4. TJJD Professional Development Lesson Plan including a narrative with Key Points
5. Shift and search logs

Interviews:

1. Compliance Officer
2. Superintendent
3. Correctional staff
4. Youth

(a): TJJD policy and the training curriculum page outline the use of cross-gender pat-down and strip searches by the opposite gender. Both state two trained staff must be present and the staff members conducting the search must be of the same gender as the youth, except in exigent circumstances. Policy allows body cavity searches only with probable cause that the youth has contraband and with the authorization of the facility administrator and must be conducted off-site by medical personnel.

(b): TJJD policy prohibits cross-gender pat-down searches except in exigent circumstances and defines such circumstance but does not provide specific examples. Policy also requires that staff members honor a youth's preference to be searched by a male or female staff member if the youth identifies as transgender or intersex. During interviews, all youth reported being pat searched by a same-gender staff member, and none reported being searched by a cross-gender staff member. Currently one youth at EJRC identifys as transgender. Interviews with the youth, Superintendent, Youth Rights Specialist, and Compliance Officer indicated the youth was pat searched according to her preference. Youth verbalized satisfaction with the "housing/living plan" that had been developed for her. Staff interviewed seemed to utilize "cross-gender" and "transgender" pat searches interchangeably indicating a possible confusion between the 2 terms.

(c): TJJD policy requires that all room and pat-down searches, including any performed by cross-gender staff, are documented. Search logs were provided prior to and during the on-site audit and included the dorm, youths' names, items found, reason for the search, and the staff member who conducted the search. No cross-gender pat-down searches were noted.

(d): TJJD policy prohibits cross-gender supervision during shower and restroom routine and when youth change clothes except in exigent circumstances or when such viewing is incidental to routine room checks. Live video was reviewed for cameras in two (2) of the dorms during personal hygiene/shower routine time one evening, as well as observation from the control rooms. Although cross-gender supervision was not observed during this time it was noted that staff (male or female) walking through the control room at any given time, including shower times could possibly view youth entering or exiting the shower area.

Staff members of the opposite gender are required to announce their presence when entering living units, and signs are posted reminding them to do so. Staff members and youth reported the practice of announcing opposite-gender staff members is consistently followed. A sample of Daily Dormitory Shift Logs included notations of occurrences when opposite-gender staff members announced their presence on the dorm.

(e): TJJD policy prohibits searching or examining a transgender or intersex youth for the sole purpose of determining the youth's genital status. During the audit, one youth at ERJC identified as transgender. Staff members communicated an understanding of the policy during interviews.

(f): TJJD policy requires that room and pat-down searches are conducted in a professional manner, and staff must not make jokes, conversation, or comments while conducting searches. Policy also requires that staff conducting a pat-down search must be of the same gender as the youth being searched, except in circumstances. However, policy does not include the procedures specific to conducting cross-gender pat-down searches and searches of transgender and intersex youth. Sign-in sheets indicated staff attended a recent Town Hall Meeting titled "Cross-Gender Script." Some staff mentioned the training during interviews, others did not. New Hire PREA Training and Annual Training records indicate all staff members receive PREA-related training, but the On-the-Job Training Lesson Plan provided in the folder for Standard 115.331 restates policy and does not specifically mention cross-gender pat-down procedures. Staff responded inconsistently when asked about policy specific to cross-gender pat-down searches, whether they received training related to these searches, whether ERJC allows such searches in exigent circumstances, and what constitutes an exigent circumstance.

Corrective Action: Yes

1. Provide additional training to address staff members' inconsistent responses regarding cross-gender pat-down searches; and the terms "cross-gender" and "transgender" pat search needs to be clarified. Provide a curriculum page or lesson plan detailing the procedures for cross-gender pat-down searches.

   A training module titled "Cross Gender Search" was provided and reviewed by the auditors. Although the module states that participants will gain the skills necessary to perform a cross-gender pat search, the steps to be taken by staff only include procedures for conducting a cross-gender visual search. The corrective action for this standard will remain until evidence is provided that the curriculum has been revised to include procedures for cross-gender pat down searches and documentation is provided that shows staff members have been trained on how to perform such searches. Additional interviews will be conducted during the 180-day corrective action period to confirm staff members' understanding of these searches and exigent circumstances in which they would be warranted.

Corrective Action since the Audit:

1. The PREA Compliance Director provided a script that is read by facility administrators during town hall meetings. The script:

   - States that cross-gender pat searches are only allowed in exigent circumstances
   - Provides examples of exigent circumstances
   - Indicates cross-gender pat searches are demonstrated during the town hall meeting
   - Defines transgender and intersex
   - States youths' gender preference is assessed monthly
   - States air (non-touch) searches are no longer allowed for any youth

   The revised OJT Training Module titled *Pat and Cross-Gender Search Procedures* outlines the steps for all pat searches conducted on male and female youth. A section titled *Cross-Gender, Transgender, and Intersex Searches* includes TJJD Policy regarding these types of searches and contains all of the information that is included in the script described above.

   Training records (Credit for Informal Instruction -TRN-955) indicate staff members at Evins attended campus wide (Town Hall) meetings/training on October 2, 2017 and dorm meetings where they received instruction on *Cross-Gender and Transgender Searches.* Signatures on the TRN-955 form acknowledge attendance and understanding of the training.

   Additionally the agency implemented a new curriuclum "Gender & Sexuality: A Changing Perspective" which included more information on PAT searches. The PAT search training video was also reviewed. During follow up interviews, staff members reported receiving training regarding the facility's practice regarding cross-gender pat down searches during facility and dorm meetings - instruction sessions. They could describe circumstances that would warrant a cross-gender pat search and demonstrated an understanding of the facility's policy regarding these searches. The facility Compliaance Officer also distributed to all staff a quick reference guide on the definitions of cross gender and transgender, as well as First Responders duties.

Standard 115.316 Residents with disabilities and residents who are limited English proficient

- ☐ Exceeds Standard (substantially exceeds requirement of standard)
- ☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does Not Meet Standard (requires corrective action)

Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Documentation and Policy Reviewed:

1. Completed PAQ
2. GAP 380.9337 (e)(5)
3. ERJC list of translators
4. Contracts with special education teachers
5. PREA script in English and Spanish
6. Contract sign language interpreting service uploaded in Background section

Interviews:

1. Youth with intellectual disability
2. Youth with limited English proficiency
3. TJJD Executive Director (TJJD Central Office Interview)
4. Staff members who provide initial PREA training to youth

(a): The TJJD has taken steps to ensure youth with disabilities have equal opportunity to participate in and benefit from TJJD's efforts to prevent, detect, and respond to sexual abuse. Effective communication with these youth includes utilizing a contract with South Texas Interpreters for the Deaf, McAllen, Texas. The uploaded documents for the auditors states the language interpreting services are provided to the McAllen, Harlingen, and Edinburg areas and was dated 4/1/2013 and expired 8/31/2014. A second contract was provided for the auditors with Interpreters Unlimited, San Diego, California for all TJJD facilities. This contract indicates it was extended through 8/31/2016.

During interviews, staff stated that orientation involves a staff member reading the PREA Orientation Script to youth and asking questions to ensure youth understand the information. Youth also watch the PREA Orientation video. The script provided has a reading level of 12th to 13th grade meaning youth with college level reading skills would be able to read and/or understand the document. Additionally, excerpts from the Youth Handbook regarding PREA have an overall 8th grade reading level.

(b): TJJD has taken steps to ensure youth who are limited English proficient have equal opportunity to participate and benefit from TJJD's efforts to prevent, detect, and respond to sexual abuse. Bilingual staff members are utilized as English/Spanish translators and English and Spanish versions of the PREA Orientation Script, PREA posters, and Youth Handbooks are available. Due to the regional location of ERJC most staff are English/Spanish proficient.

(c): TJJD policy prohibits the use of youth to interpret, read, or otherwise assist except in limited circumstances. ERJC reports no occurrences of the use of youth interpreters in the last 12 months. Staff members stated they would not use youth interpreters except in exigent circumstances.

Corrective Action: Yes

The National PREA Resource Center checklist includes documents to review during the on-site portion of the audit. Two items were not present for review for this standard:

a. "Written materials used for effective communication about PREA with residents with disabilities or limited reading skills." The PREA script was reviewed but is not appropriate for youth with disabilities or limited reading skills.
b. Documentation of "staff training of PREA compliant practices for residents with disabilities."

1. Provide evidence of alternative reading materials and staff training specific to the needs of youth with reading and intellectual disabilities.

2. Provide agreement with or procedures for using a language line to provide services to ERJC youth with limited English proficiency.

3. Provide an amended or current contract with an appropriate Interpreting Services that includes ERJC.

Corrective Action since the Audit::

1. The Compliance Director requested that the TJJD education department review and revise the PREA-related pages in the Youth Handbook so that youth with disabilities or limited reading skills could access the information. A modified table with a reading level of grade 4.9 was provided to the auditors and is now included as an insert in the handbook. The table outlines sexual abuse truths and untruths adapted from the report, *Hope for Healing: Information for Survivors of Sexual Assault in Detention.* The special education department also modified the script that orientation and intake staff members read to youth upon placement at the facility. The revised documents in English and Spanish were provided in track-change mode so that each revision could be noted. Several words such as investigated, alleged, and referral were bolded within the text to call attention to words needing additional explanation during the intake process.

   During follow-up interviews, the intake and orientation staff member verified the use of the revised script and insert.

2. An agency memorandum indicates that Evins youth who are limited English proficient have access to interpreting services through a Language Line, although it stated the services were not utilized during the previous 12 months prior to the audit.

An amendment to the San Marcos Interpreting Services for the Deaf demonstrates that Evins and all TJJD facilities are now included in the contract. The amendment states that the service provides sign language interpreting services, advanced services for medical and psychological terminology, and may involve interpreting during treatment or counseling sessions.

Standard 115.317 Hiring and promotion decisions

☒ Exceeds Standard (substantially exceeds requirement of standard)

☐ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Documentation and Policy Reviewed:

1. Completed PAQ
2. GAP 380.9337 (e)(6)(A-G)
3. PRS 02.07
4. GAP 385.8181(d)(1)
5. PRS 02.08 (f)(1)(A)(ii)
6. Snapshot provided by the TJJD Human Resources Administrator showing hire date, initial and annual criminal background checks, and fingerprint dates

Interviews:

1. Human Resources administrative staff

(a): TJJD policy prohibits hiring or promoting anyone who may have contact with youth and using the services of any contractor who may have contact with youth if the person 1) has engaged in sexual abuse in a prison, lockup, community confinement facility, juvenile facility, or other institution or 2) has been convicted or civilly or administratively adjudicated of engaging or attempting to engage in such activities. Documentation of 10 randomly selected employees and contractor(s); and four additional personnel files indicated proper criminal record background checks are conducted.

(b): TJJD policy requires that for any person who may have contact with youth, TJJD consider any incidents of sexual harassment in determining whether to hire, promote, or contract for services. Interviews with Human Resources administrative staff demonstrated compliance with this practice. They said the sex offender registry is consulted annually and since all staff members are fingerprinted, any arrest would trigger notification to the Human Resources Administrator.

(c): TJJD policy requires that before hiring a new employee who may have contact with youth, TJJD conducts 1) a criminal background check, 2) child abuse registry check, and 3) contact of prior institutional employers to determine any substantiated allegations of sexual abuse or any resignation during a pending investigation of an allegation of sexual abuse. Forms placed in each personnel file include Background Reference Check, Internal Background Review, Disclosure of PREA Employment Standards Violation, and Child Abuse Registry Check Consent Form. Interviews with Human Resources administrative staff verified the practice of conducting such checks for all employees.

(d): TJJD policy requires that before enlisting the services of a contractor who may have contact with youth, TJJD performs criminal background checks and consults the Child Abuse Registry. The background check of one contractor indicates a criminal background check was conducted prior to the contractor having contact with youth. The facility reports that in the past 12 months, criminal background checks were conducted for

one contractor for services for all staff covered in the contract who may have contact with youth.

(e): TJJD conducts annual criminal background checks, which exceeds the requirement of conducting checks at least every five years. The Human Resources Administrator stated annual checks are conducted for staff, volunteers, and contractors. The initial and annual criminal background check histories of ERJC employees and additional personnel file review also support compliance with this standard.

(f): TJJD policy requires that applicants and employees who may have contact with youth have an affirmative duty to disclose misconduct described in Subsection (a). The Disclosure of PREA Employment Standards Violations form placed in each personnel file supports compliance with this subsection. The agency and facility Human Resources Administrators stated staff must disclose any misconduct.

(g): TJJD policy requires that material omissions regarding such misconduct or the provision of materially false information is grounds for termination.

(h): TJJD policy requires that unless prohibited by law, TJJD provides information on substantiated allegations of sexual abuse or harassment involving a former employee upon receiving a request from an institutional employer for whom the former employee has applied to work. Interviews with Human Resources Administrators support compliance with this practice.

Corrective Action: None

Standard 115.318 Upgrades to facilities and technologies

- ☐ Exceeds Standard (substantially exceeds requirement of standard)
- ☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does Not Meet Standard (requires corrective action)

Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Documentation and Policy Reviewed:

1. Completed PAQ
2. Facility map with buildings and camera numbers

Interviews:

1. Superintendent
2. Executive Director (TJJD Central Office Interview)

(a): This subsection is not applicable, as the facility has not made substantial expansions or modifications.

Recommendation: Additional cameras be installed in the kitchen/cafeteria pantry to ensure safety of youth

and staff in this area.

Corrective Action: None

Standard 115.321 Evidence protocol and forensic medical examinations

- ☐ Exceeds Standard (substantially exceeds requirement of standard)
- ☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does Not Meet Standard (requires corrective action)

Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Documentation and Policy Reviewed:

1. Completed PAQ
2. GAP 380.9337 (f)
3. GAP 385.8183
4. Doctor's Hospital at Renaissance, Edinburg, Texas (SANE/SAFE)
5. Women's Shelter of South Texas MOU

Interviews:

1. Staff members
2. OIG investigators
3. Compliance Officer
4. Youth

(a): The TJJD Office of the Inspector General (OIG) is responsible for conducting all criminal investigations. The Administrative Investigations Division (AID) conducts all other sexual abuse and harassment allegations involving staff members. The OIG investigators generally work Monday through Friday but are on call during non-work hours. When sexual abuse allegations are made, the facility procedures are outlined in policy and the ERJC Written Plan of Coordinated Response to Allegations of Sexual Abuse. Discrepancies in first responder duties are addressed in Standard 115.365. Staff members communicated an understanding of the collection of evidence and understood that OIG and AID are responsible for conducting investigations.

(b): The investigators follow a uniform evidence protocol, *A National Protocol for Sexual Assault Medical Forensic Examinations: Adults/Adolescents, Second Edition, April 2013.*

(c): TJJD policy requires that when appropriate, TJJD transports youth who experience sexual abuse to a hospital that can provide a medical examination by a SANE or SAFE. If such exams are necessary, ERJC transport youth to Doctor's Hospital at Renaissance in Edinburg, Texas. This agreement was corroborated during the interview with the SAFE/SANE. TJJD policy requires that medical examinations by a SAFE/SANE are provided at no financial cost to the youth.

(d): An MOU with The Women's Shelter of South Texas, a local sexual assault shelter, indicated an agreement was established to provide services. Victim advocacy services would be provided if needed. The MOU indicates the phone number to the shelter is provided to youth who do not feel comfortable speaking with facility mental health professionals. During interviews, the majority of youth were not aware of this or any outside service. The Compliance Officer interview responses supported compliance with this practice.

(e): A list of mental health professionals was provided as potential staff members who are available to accompany and support the victim through the forensic medical examination process and investigatory interviews and to provide emotional support, crisis intervention, information, and referrals. The outside shelter's phone number is not posted in visiable locations.

(f): This subsection is not applicable as the agency is responsible for conducting administrative and criminal investigations.

(g): This subsection is not applicable as the agency is responsible for conducting administrative and criminal investigations.

(h): The TJJD OIG is responsible for conducting all criminal investigations. The AID conducts all other sexual abuse and harassment allegations involving staff members. All investigators have been screened to serve in this role through the TJJD Human Resources screening process, which includes a Background Reference Check, Internal Background Review, Disclosure of PREA Employment Standards Violation, and Child Abuse Registry Check Consent Form. In addition to the general PREA training, TJJD policy requires that TJJD staff members who investigate allegations of sexual abuse receive specialized training that includes interviewing juvenile sexual abuse victims and evidence collection. The auditors verified the two AID and two OIG facility investigators' certificates of completion of *PREA: Investigating Sexual Abuse in a Confinement Setting* by the National Institute of Corrections. The investigators follow a uniform evidence protocol, *A National Protocol for Sexual Assault Medical Forensic Examinations: Adults/Adolescents, Second Edition, April 2013.* TJJD policy requires that an off-site Sexual Assault Nurse Examiner or Sexual Assault Forensic Examiner conduct forensic medical exams. During interviews, the investigators stated they received training specific to conducting investigations in a confinement setting, interviewing techniques, and collecting evidence, and understood agency policy and practices regarding forensic examinations.

Corrective Action: Yes

1. At a minimum the Shelter's phone number be posted in each case manager's office and other appropriate administrative offices. Follow up will be completed to ensure the posting has been completed.
2. During the facility orientation process the availability of outside resources for counseling and support should be emphasized with youth. Additional review of this available service through out a residents stay at ERJC should be completed and documented.

Corrective Action since the Audit::

1. During the follow up on site visits June 20th and November 16th, 2017 the Shelter's phone number was found posted in case manager's and mental health provider's offices across campus.
2. Youth interviewed on November 16th confirmed they had knowledge of outside resources for additional counseling and support.

Standard 115.322 Policies to ensure referrals of allegations for investigations

☐ Exceeds Standard (substantially exceeds requirement of standard)

☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Documentation and Policy Reviewed:

1. Completed PAQs
2. GAP 380.9337 (f)(2)(A), (k)(1)

Interviews:

1. TJJD Executive Director (TJJD Central Office Interview)
2. Investigative staff members
3. TJJD website: http://www.tjjd.texas.gov/

(a): The TJJD is responsible for conducting both criminal and administrative investigations. Policy outlines the responsibility of the OIG to review all allegations of sexual abuse and harassment and assign each allegation to the appropriate TJJD department to complete a criminal or administrative investigation. A uniform evidence protocol, *National Protocol for Sexual Assault Medical Forensic Examinations, Second Edition, April 2013*, is used that maximizes the potential for obtaining usable physical evidence for administrative proceedings and criminal prosecutions. The Executive Director said that all investigations must be completed and provided the average length of time for investigation completion.

ERJC, OIG, and AID reported different totals of allegations of sexual abuse and sexual harassment received over that past 12 months on their respective PAQs. OIG reported 25 cases, AID reported 17 cases, and ERJC reported 11 youth notifications of completed investigations.

Reporting Entity	Number of Allegations Received 115.322	Resulting Administrative Investigations 115.322	Referred for Criminal Investigation 115.322	Were all investigations completed? 115.322	Number of Grievances Filed 115.352	Completed within 90 Days 115.352	Number of Allegations 115.364	Notified within Timeframe for Evidence Collection 115.364	Number of Criminal/Administrative Investigations 115.373	Of the Completed Investigations, Number of Youth Notifications 115.373
Facility	Not answered									11
AID	17	17	Unknown	No	unknown	16	17	Not included in AID PAQ		
OIG	25	Unknown	25	yes	unknown	25	25	Not included in OIG PAQ		

(b): TJJD policy requires that all allegations of sexual abuse or harassment are reported to the TJJD OIG,

which reviews, assigns, and documents each allegation. Policy governs both administrative and criminal investigations and is posted on the TJJD website. During interviews, investigative staff supported compliant investigative practices.

(c): This subsection does not apply; the agency is responsible for conducting administrative and criminal investigations.

(d): This subsection does not apply; the agency is responsible for conducting administrative and criminal investigations.

(e): This subsection does not apply; the agency is responsible for conducting administrative and criminal investigations.

Corrective Action: Yes

1. The PAQ asks for an explanation of any administrative or criminal investigation that was not completed. Since the facility and AID reported one investigation was not completed, provide an explanation of the incomplete investigation.

2. Provide an explanation for the discrepancy in the total number of allegations and investigations reported by the facility, AID, and OIG.

Corrective Action since the Audit:

1. The remaining 1 investigation had not concluded within the audit period but was within the 90-day closure requirement. No investigations were delinquent or incomplete.

2. The OIG Inspector General and Director provided a memorandum explaining the discrepancies in the table above. The reasons for the different totals follow.

- There are three or more agency divisions, which may receive reports or allegations.
- The divisions may properly or improperly classify incidents as PREA-related based on their assessment of the incident.
- Facility staff may over or incorrectly report incidents as being PREA related.
- AID and OIG correct the erroneously classified reports. For example, the facility may classify an incident as a PREA incident, but after further investigation, the AID or OIG may reclassify the incident as non-PREA. This results in discrepancies in the total number of PREA-related incidents reported by each entity.
- The opening of investigations may begin prior to or during the audit period but not close until after the audit period concludes, thus the difference in the number of investigations reported on the PAQ that were opened and completed.

During follow-up interviews, the OIG Inspector General and OIG investigator stated the actions following each type of report that is called into the IRC. The investigator said that he reviews each call and assigns the cases to the appropriate entity. OIG actions following calls alleging sexual abuse vary depending on the nature of the report. If a youth reports staff-on-youth sexual abuse or harassment, the OIG notifies appropriate parties including the facility superintendent, assistant superintendent, administrator on duty, AID, and an OIG investigator. An investigator is also dispatched to the facility. If a youth reports youth-on-youth sexual abuse or harassment, an IRC case is assigned, an OIG investigator is sent to the facility, and if any indication of staff neglect is present, AID is notified and a case assigned. If other parties

such as staff members wishing to remain anonymous or parents make reports directly to the IRC, the call is handled as a staff-on-youth sexual abuse report, and appropriate notifications are made to facility administrators, AID, and OIG.

Standard 115.331 Employee training

- ☐ Exceeds Standard (substantially exceeds requirement of standard)
- ☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does Not Meet Standard (requires corrective action)

Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Documentation and Policy Reviewed:

1. Completed PAQ
2. GAP 380.9337 (g)(1)(A)
3. PREA and Preventing Sexual Misconduct staff development lesson plan with course description, performance objectives, materials
4. Direct Care Staff New Hire Development: Juvenile Health lesson plan
5. OJT Juvenile Health lesson plans
6. PREA Training and Acknowledgment Form and Sign-In Sheet for Annual Training of medical and mental care staff
7. Meeting the Needs of Gender-Diverse Youth training PowerPoint
8. Relational Language Handout
9. Town Hall Sign-In Sheets for "Cross-Gender Script" training

Interviews:

1. Medical and Mental Health Care staff members
2. Random staff members

(a): TJJD policy requires all staff members who may have contact with youth attend training that addresses each of the 11 elements in this subsection. During interviews, medical and mental health care staff and random staff members reported they had been trained on each element during new-hire and annual refresher training and received PREA-specific trainings during Town Hall and dorm meetings. Lesson plans address each item and provide an overview of the PREA as well as TJJD policy and practices related to sexual abuse.

(b): The training materials are tailored to the unique needs of juveniles and address gender-specific communication. The provided Relational Language handout includes brief strategies for communicating with female juveniles but does not appear to be gender-specific other than using the words her, she, and girl. TJJD policy requires additional training if an employee is reassigned from a facility that houses only male youth to a facility that houses only female youth.

(c): The facility reports employees are all trained or retrained on the PREA requirements outlined in Subsection (a).

(d): Town Hall and Dorm Meeting Sign-In Sheets and Campus PREA Training Sing-In Sheets and Acknowledgment Forms supported compliance with TJJD policy and this subsection requirement to document that employees received and understood the PREA training.

Corrective Action: None

Standard 115.332 Volunteer and contractor training

- ☐ Exceeds Standard (substantially exceeds requirement of standard)
- ☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does Not Meet Standard (requires corrective action)

Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Documentation and Policy Reviewed:

1. Completed PAQ
2. GAP 380.9337 (g)(2)
3. Volunteer Roster
4. Volunteer Training records

Interviews:

1. Volunteers who have contact with youth
2. Volunteer Coordinator

(a): TJJD policy requires that all volunteers and contractors who have direct access to youth are trained on and understand their PREA-related responsibilities and procedures. The facility volunteer roster indicates there are 81 volunteers. During interviews, volunteers reported receiving a three-hour training on their responsibilities regarding sexual abuse prevention, detection, and response. They said they were trained on how to make a report, what should be reported, and how to identify the signs of abuse. They reported receiving a packet that was reviewed with the facilitator during the training session.

(b): The facility reports that the level and type of training the volunteers and contractors receive is based on the services they provide and level of contact with youth. The 2011 Edition of the Volunteer Training Manual includes a comprehensive list of PREA-related topics.

(c): A sample of Volunteer Training records was reviewed. Training documents did not indicate long tenured volunteers had not received PREA training that had been implemented in the 2011 Volunteer Training. Training records indicated no further training on PREA was provided to Voulteers other than the initial orientation/training. Volunteer Coorindator indicated no annual training was provided to volunteers

regarding PREA.

Corrective Action: None
Recommendation: Although the standard does not specifically require annual PREA training for volunteers it is assumed best practice would require an annual "refresher" training; just as it is with employees. Therefore it is recommended volunteers receive annual PREA training.

Recommendation Follow Up: The agency accepted the recommendation and provides various means for volunteers to receive annual "refresher" training on PREA requirements and reporting requirements.

Standard 115.333 Resident education

- ☐ Exceeds Standard (substantially exceeds requirement of standard)
- ☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does Not Meet Standard (requires corrective action)

Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Documentation and Policy Reviewed:

1. Completed PAQ
2. GAP 380.9337 (g)(3)

Interviews:

1. Intake staff
2. Random youth

(a): All youth committed to the TJJD begin their stay at the Ron Jackson O&A unit. Agency policy requires that youth receive comprehensive, age-appropriate information about TJJD's zero-tolerance policy and how to report incidents of sexual abuse or harassment. Each time a youth transfers to a different TJJD facility, they receive the same information upon arrival at that facility. The agency reports from January 2016 to January 2017, 870 youth received the comprehensive PREA education at the O&A unit. At ERJC the auditors reviewed 13 youth masterfiles that were randomly selected and requested by the auditors on site. Each file included the Youth Orientation Checklist, PREA Orientation Training and Acknowledgment Form, and Receipt of Youth Handbook Form. Also present were dated youth and staff witness signatures confirming youth participation in PREA education during the intake process. Zero Tolerance posters in Spanish and English were present in the intake area and displayed throughout the campus.

(b): TJJD policy requires that within 10 calendar days of admission to the facility, TJJD provides comprehensive, age-appropriate education to youth about 1) their right to be free from sexual abuse or harassment and retaliation for reporting such incidents and 2) TJJD policy and procedures for responding to such incidents. During interviews, staff stated that upon admission, staff members read the English or Spanish version of the PREA Orientation Script to youth and show the PREA video, *Safeguarding Youth Sexual*

Safety PREA Orientation. Follow-up questions are asked to ensure the youth comprehends the information. Youth watch the video again, and staff members provide additional PREA education. Youth supported this practice during interviews and said they received the education and watched the PREA video.

(c): TJJD policy requires that TJJD provide the PREA education each time a youth transfers to a different TJJD-operated facility. Staff and youth interviews supported compliance with this practice.

(d): TJJD policy requires that the agency provide PREA information in formats accessible to all youth including those who are limited English proficient, deaf, visually impaired, otherwise disabled, or have limited reading skills. The PREA Script and Youth Handbook contain PREA-related information but are not accessible to all youth. These documents are discussed in Standard 115.316.

(e): TJJD documents youth participation in PREA education by requiring youth to acknowledge their understanding by signing and dating the PREA Orientation Acknowledgment Form. The auditors reviewed 13 youth masterfiles that were randomly selected and requested by the auditors on site. Each file included the Youth Orientation Checklist, PREA Orientation Training and Acknowledgment Form, and Receipt of Youth Handbook Form. Also present were dated youth and staff witness signatures showing youth participation in PREA education during the intake process. Youth confirmed participation in these steps.

(f): PREA information is available and visible to youth through posters and Youth Handbooks in English and Spanish. The auditors noted the posters were visible in living units and common areas during the facility inspection. Youth said they receive PREA-related information during intake, again once they are assigned to a dorm, and continuously throughout their stay.

Corrective Action: Yes

1. For standard 115.316, the auditors requested alternative reading materials and staff training specific to the needs of youth with reading and intellectual disabilities, an agreement with or procedure for using a language line, and an updated contract for translator service. Standard 115.333 also requires that PREA education is provided to youth in formats accessible to all youth. Once the alternative reading materials requested for 115.316 are provided, the requirement for Standard 115.333 will also be satisfied.

Corrective Action since the Audit:

1. The Compliance Director requested that the TJJD education department review and revise the PREA-related pages in the Youth Handbook so that youth with disabilities or limited reading skills could access the information. A modified table with a reading level of grade 4.9 was provided to the auditor and is now included as an insert in the handbook. The table outlines sexual abuse truths and untruths adapted from the report, *Hope for Healing: Information for Survivors of Sexual Assault in Detention.* The special education department also modified the script that orientation and intake staff members read to youth upon placement at the facility. The revised documents in English and Spanish were provided in track-change mode so that each revision could be noted. Several words such as investigated, alleged, and referral were bolded within the text to call attention to words needing additional explanation during the intake process.

During follow-up interviews, two youth identified as having a learning disability stated that they understood the PREA-related information they received during intake. They reported receiving the Youth Handbook, understanding the PREA information, receiving PREA education periodically on the dorm, and having access to PREA information posted in their dorms.

Standard 115.334 Specialized training: Investigations

- ☐ Exceeds Standard (substantially exceeds requirement of standard)
- ☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does Not Meet Standard (requires corrective action)

Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Documentation and Policy Reviewed:

1. Completed PAQ
2. GAP 380.9337 (g) (4)

Interviews:

1. Investigative staff
2. TJJD AID training agenda and lesson plan
3. Certificates of Completion of National Institute of Corrections Training

(a): In addition to the general PREA training, TJJD policy requires that TJJD staff members who investigate allegations of sexual abuse receive specialized training that includes interviewing juvenile sexual abuse victims. The auditors verified the two AID and two OIG facility investigators' certificates of completion of *PREA: Investigating Sexual Abuse in a Confinement Setting* by the National Institute of Corrections (NIC). The investigators stated they received this training, which included interviewing techniques, evidence collection, and use of Miranda and Garrity warnings.

(b): TJJD policy requires investigator training that addresses the elements of this standard. The NIC training includes each element. The two investigators interviewed said they received training regarding Miranda and Garrity warnings. The AID investigator said she would use the Garrity warning for any staff members under administrative investigation, and the OIG investigator stated OIG would use Miranda when a staff member is the suspect.

(C): The auditors verified certificates of completion of the required training for the AID and OIG facility investigators.

(d): This subsection does not apply; the agency is responsible for conducting administrative and criminal investigations.

Corrective Action: None

Standard 115.335 Specialized training: Medical and mental health care

☐ Exceeds Standard (substantially exceeds requirement of standard)

☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Documentation and Policy Reviewed:

1. Completed PAQ
2. GAP 380.9337(g)(5)
3. Certificates of Completion of PREA Training

Interviews:

1. Medical and mental health care staff

(a): TJJD policy requires that full- and part-time medical and mental health staff are trained in how to detect and assess signs of sexual abuse, preserve physical evidence, respond to victims of sexual abuse, and report allegations or suspicions of sexual abuse. Certificates of Completion of the online course *PREA: Behavioral Health Care for Sexual Assault Victims in a Confinement Setting* by NIC were reviewed for ERJC mental and medical health practitioners. An Annual PREA Training Acknowledgment Form and Sign-in Sheet included signatures indicating attendance and understanding of the training. Medical and mental healthcare staff members said they received new hire and annual PREA-related training at ERJC.

(b): This subsection is not applicable; TJJD policy requires that an off-site Sexual Assault Nurse Examiner or Sexual Assault Forensic Examiner conduct forensic medical exams.

(c): The auditors reviewed documentation to verify that medical and mental health care staff received appropriate PREA training. In addition to the NIC online training, all staff members attend annual training, which includes PREA-specific topics.

(d): TJJD policy requires that full- and part-time medical and mental health staff are trained in each of the 11 required elements outlined in Standard 115.331 (a). Lesson plans address each item and provide an overview of the PREA as well as TJJD policy and practices related to sexual abuse. Certificates of Completion of the online course *PREA: Behavioral Health Care for Sexual Assault Victims in a Confinement Setting* by NIC were reviewed for ERJC mental and medical health care staff members. During interviews, medical and mental health care staff reported they had been trained on each element during new hire and annual refresher training and received PREA-specific trainings at ERJC.

Corrective Action: None

Standard 115.341 Screening for risk of victimization and abusiveness

☐ Exceeds Standard (substantially exceeds requirement of standard)

☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Documentation and Policy Reviewed:

1. PAQ
2. GAP 380.9337 (h)(1)
3. Intake Screening for Potential Sexual Aggressive Behavior and/or Sexual Victimization
4. Exit Staffing Overview
5. Safe Housing Assessment/Reassessments in the Correctional Care System (TJJD online database)

Interviews:

1. Random youth
2. Staff responsible for risk screening
3. Compliance Officer
4. PREA Compliance Director (TJJD Central Office Interview)

(a): TJJD policy requires that within 72 hours of intake at the Ron Jackson O&A unit and periodically throughout their confinement, an objective assessment is used to obtained information about each youth's history and behavior to reduce the risk of sexual abuse by or upon another youth. Policy also requires that information from the screening instrument is used periodically throughout the youth's stay to reassess housing and supervision assignments. The intake case managers complete an additional safe housing assessment prior to assigning a youth to a dorm or room. A safe housing reassessment is also completed upon facility transfer, at least once every 90 days, automatically within one day of a major rule violation proven true in a hearing, turning age 17, or following a serious suicide attempt.

The auditors reviewed a Safe Housing Report generated by the Correctional Care System, which indicated all safe housing reassessments for ERJC youth were current. While the safe housing reassessment is used periodically and all were current, the reassessment does not address the 11 items per Subsection (c). The 11 items are discussed with youth only during intake and not fully addressed again throughout the youth's stay in the TJJD.

The agency PREA Compliance Director stated that TJJD reassesses a youth every 90 days or sooner under certain circumstances and that the reassessment form covers several of the 11 elements for this standard. He also said that the purpose of the form is for periodic assessment of the sexual safety of a youth and their potential for being victimized and/or abused. Although youth are reassessed using the reassessment form during Multi-Disciplinary Team MDT meetings, the form does not include each of the 11 elements, and it is not clear if the youth is asked all 11 items during the MDT meeting.

During interviews, staff members reported using the information from the intake screening tool and the additional safe housing assessment to make room assignment decisions. Subsequent housing placement decisions are based solely on the safe housing reassessment, which does not address the 11 items in Subsection (c). Youth said they were asked the questions outlined in Subsection (c) during intake but did not remember being asked the questions again throughout their stay.

(b): The auditors reviewed each assessment and determined the intake assessment, safe housing assessment, and safe housing reassessment are objective screening instruments.

(c): The intake assessment form is used to obtain the 11 items per this standard, but the assessment is not used again during the youths' confinement including when youth reenter the Ron Jackson O&A Unit after being released and then recommitted by a court. The safe housing reassessment is used for all future housing decisions. A discussion of the assessments is included in (a) above.

(d): Staff indicate review of the youth's file, court records, history, prior commitment types, prior abuse or victimization, mental health screenings, and any other documentation included in the youth's file before interviewing the youth during intake process at the facility.

(e): TJJD policy establishes appropriate controls to prevent sensitive information obtained from these screenings from being exploited to the youth's detriment by staff or other youth. During interviews, facility staff members stated the information from the screenings is limited to medical and mental health care staff, the youth's case manager, and supervisory staff.

Corrective Action: Yes

1. While TJJD policy requires that the objective screening instrument is used periodically throughout the youth's stay to reassess housing and supervision assignments, the initial intake screening tool, which includes the 11 items used to assess risk, is only used once during intake. Revise the safe housing reassessment to include all 11 items as outlined in Subsection (c) or provide evidence that the items are considered and documented during MDT meetings or other periodic meetings with youth. Additional interviews will be conducted with youth during the 180-day corrective action period.

Corrective Action since the Audit:

1. As of September, the revised safe housing reassessment (CCF-036) still did not include all 11 items used to assess risk pursuant to this standard. Auditors requested additional information from the Compliance Director via email, and the Director provided a draft of the revised reassessment that included the 11 items and a plan to implement the new form. On September 19, a notice was sent to facility superintendents informing them that the new document, which was attached in draft form, was to be used to conduct all youth reassessments that were due on September 22. Since this did not demonstrate institutionalization of the new form, additional information was requested to determine whether:

    - The new form in use at the facility was an approved or draft version
    - The form was in queue to replace the previous version on the agency's Correctional Care System
    - Training had occurred regarding the use of the new form

    Auditors were notified that the revised form had not been finalized and was not in queue. After a

discussion with the Compliance Director, the following additional corrective actions were initiated on October 12. These included:

- Scheduling a video conference to provide information and train staff members regarding the use of the revised form
- Providing a list of youth whose reassessments were due in October
- Explaining how the new form would be used in addition to the current electronic version rather than replacing the electronic version with the hard copy revised version
- Plan for filing the hard copy of the new reassessment until the current electronic one was replaced
- Evidence that the form was in queue and that a projected date of implementation was established

On October 16, the video conference was held with the Compliance Director and facility staff members regarding the implementation of the new form including the purpose, due dates of reassessments, and where the form was to be filed. Also on October 16, the auditors were provided an approved reassessment form, a youth acknowledgment form that he or she was reassessed, and evidence from the TJJD Director of Application Development that the new form was in queue with a preliminary estimation of completion, which is the end of the year or longer. On October 17, sign-in sheets acknowledging receipt and understanding of the professional development titled *Completion of the Revised CCF 036 Form* was provided and indicated facility supervisors, case managers, and placement coordinators received and understood the training. Also on this date, completed reassessments that were due in September and October and youth reassessment acknowledge statements were provided. Additional reassessments using the new form and the current digital form were emailed in batches as they were conducted in October and November. In addition to documentation supporting compliance with this standard, the Compliance Director, Senior Director of State Programs and Facilities, and Director of Monitoring and Inspections ensured that the process would be monitored and each facility held accountable for using the revised reassessment. During the on site follow up visit 8 youth were interviewed and 2 case managers. They were familiar with the Safe Hosuing Assessment and Re-Assessment procress. Twenty-two sets of the new re-assessement instrument were provided to the auditors for review from September through November. This demonstrates the institutionalization and complianace with the new process pending the electronic implementation, once it has been added to the agency's Correctional Care System (CCS).

Standard 115.342 Use of screening information

☐ Exceeds Standard (substantially exceeds requirement of standard)

☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Documentation and Policy Reviewed:

1. GAP 380.9337(h)(2)
2. GAP 380.9745 (d)(2)
3. GAP 380.9739

Interviews:

1. Compliance Officer
2. Staff responsible for risk screening
3. Superintendent

(a): TJJD policy requires that information obtained using the screening instrument is used to reassess housing and supervision assignments. However, the reassessment used throughout the youth's stay does not include all 11 items pursuant to Standard 115.341. The Compliance Officer and staff members responsible for intake risk screening stated the initial screening instrument is used only once during intake. Subsequent decisions are made using the information obtained in the safe housing reassessment, which does not include all 11 items. Interviews with staff verified this is this practice.

(b): TJJD policy requires that 1) except under limited situations involving self-injury, TJJD does not place youth in isolation as a means of protection, 2) the placement of youth in protective custody is used only as a last resort, and 3) youth in protective custody receive all standard service delivery and programming requirements. The facility reports that no youth at risk of sexual victimization were held in isolation in the past 12 months. Interviews with staff verified compliance with this practice.

(c): TJJD policy requires that LGBTI youth are not placed in particular housing, beds, or other assignments on the basis of such identification. During interviews, the youth who identified as LGBTI reported not being placed in a dorm based on this status. Interviews with staff verified compliance with this practice.

(d): TJJD policy requires that for each transgender or intersex youth, TJJD makes a case-by-case determination when assigning the youth to a male or female facility. The PREA Compliance Officer said all decisions are made on a case-by-case and after consultation with the Superintendent, mental health care staff members, and Central Office staff members. One youth who identified as transgender was in placement at the facility during the on site audit. ERJC is an all male facility the transgender youth has had dorm re-assignments based on the youth's preference and determinations made by facility staff members regarding the youth's well-being and safety. During the youth interview with the auditor she stated she was comfortable in her current dorm placement and felt safe. Staff members received additional training specific to the needs of this youth.

(e): TJJD policy requires that placement and programming assignments are assessed at least twice per year. Interviews with staff verified compliance with this practice. The Compliance Officer said that ongoing consideration was provided for the transgender youth. This was supported with documentation showing the youth was placed on two male dorms thus far at ERJC, and during interviews with the youth, Superintendent, and Compliance Officer.

(f): TJJD policy requires TJJD to consider the youth's own views concerning his or her own safety when making placement and programming assignments. The Superintendent, PREA Compliance Director, and Compliance Officer corroborated this practice during interviews. Documentation of housing placements for the transgender youth indicated the youth was placed on two dorms thus far at ERJC.

(g): TJJD policy requires that transgender or intersex youth are provided the opportunity to shower separately from other youth. Interviews with staff verified compliance with this practice for the youth who

was placed at the facility, and by the youth.

(h): The facility reports that no youth at risk of sexual victimization were held in isolation in the past 12 months. Interviews with staff verified compliance with this practice.

(i): TJJD policy exceeds the 30-day review requirement and requires that at least once every 48 hours following a youth's admission into protective custody, the designated mental health professional reviews the documentation relating to the protective custody, including the youth's treatment plan and any other documentation relating to the youth's stay in protective custody. The staff responsible for monitoring youth in isolation/the security unit said the youth may be placed for up to five days with the approved 24-hour extensions, and timeframes beyond that require approval from supervisors and Central Office staff.

Corrective Action: Yes

1. While TJJD policy requires that the objective screening instrument is used periodically throughout the youth's stay to reassess housing and supervision assignments, the initial intake screening tool, which includes the 11 items used to assess risk, is only used once during intake. For Standard 115.341, the auditors requested the safe housing reassessment be revised to include the 11 items pursuant to Subsection (c) or provide evidence that all of the items are considered and documented during Multi-Disciplinary Team meetings or other periodic meetings with youth. Once the corrective action is completed for Standard 115.341, the corrective action for Standard 115.342 will also be satisfied.

Corrective Action since the Audit:

As of September 12, the revised safe housing reassessment (CCF-036) still did not include all 11 items used to assess risk pursuant to this standard. Auditors requested additional information from the Compliance Director via email, and the Director provided a draft of the revised reassessment that included the 11 items and a plan to implement the new form. On September 19, a notice was sent to facility superintendents informing them that the new document, which was attached in draft form, was to be used to conduct all youth reassessments that were due on September 22. Since this did not demonstrate institutionalization of the new form, additional information was requested to determine whether:

- The new form in use at the facility was an approved or draft version
- The form was in queue to replace the previous version on the agency's Correctional Care System
- Training had occurred regarding the use of the new form

Auditors were notified that the revised form had not been finalized and was not in queue. After a discussion with the Compliance Director, the following additional corrective actions were initiated on October 12. These included:

- Scheduling a video conference to provide information and train staff members regarding the use of the revised form
- Providing a list of youth whose reassessments were due in October
- Explaining how the new form would be used in addition to the current electronic version rather than replacing the electronic version with the hard copy revised version
- Plan for filing the hard copy of the new reassessment until the current electronic one was replaced

- Evidence that the form was in queue and that a projected date of implementation was established

On October 16, the video conference was held with the Compliance Director and facility staff members regarding the implementation of the new form including the purpose, due dates of reassessments, and where the form was to be filed. Also on October 16, the auditors were provided an approved reassessment form, a youth acknowledgment form that he or she was reassessed, and evidence from the TJJD Director of Application Development that the new form was in queue with a preliminary estimation of completion, which is the end of the year or longer. On October 17, sign-in sheets acknowledging receipt and understanding of the professional development titled *Completion of the Revised CCF 036 Form* was provided and indicated facility supervisors, case managers, and placement coordinators received and understood the training. Also on this date, completed reassessments that were due in September and October and youth reassessment acknowledge statements were provided. Additional reassessments using the new form and the current digital form were emailed in batches as they were conducted in October and November. In addition to documentation supporting compliance with this standard, the Compliance Director, Senior Director of State Programs and Facilities, and Director of Monitoring and Inspections ensured that the process would be monitored and each facility held accountable for using the revised reassessment. During the on site follow up visit 8 youth were interviewed and 2 case managers. They were familiar with the Safe Hosuing Assessment and Re-Assessment procress. Twenty-two sets of the new re-assessement instrument were provided to the auditors for review from September through November. This demonstrates the institutionalization and complianace with the new process pending the electronic implementation, once it has been added to the agency's Correctional Care System (CCS).

Standard 115.351 Resident reporting

☐ Exceeds Standard (substantially exceeds requirement of standard)

☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Documentation and Policy Reviewed:

1. Completed PAQ
2. GAP 380.9337 (i)(1)
3. TJJD Employee Handbook
4. Youth grievances alleging sexual abuse or harassment that staff reported to the IRC
5. Memo from Superintendent detailing reporting options for staff

Interviews:

1. Random staff members
2. Youth

3. Youth who reported a sexual abuse
4. Compliance Officer

(a): TJJD policy requires that youth may report sexual abuse or harassment, retaliation, and staff neglect by: 1) filing a written grievance, 2) calling the OIG hotline, 3) telling a staff member, volunteer, or contract employee, or 4) calling the Office of the Independent Ombudsman (OIO). During interviews, youth were able to articulate the various ways to make a report, but many said they would not be able to do so privately or anonymously. Several youth were unaware they could contact the OIO as a reporting source.

(b): TJJD provides youth access to the OIO as a way to report abuse or harassment to an entity outside of the agency. The OIO's phone number and address is included in the Youth Handbook and posted throughout the facility and in each dorm. Youth said they had access to this information.

(c): TJJD policy requires that reports made verbally, in writing, anonymously, and from third parties are accepted and must promptly be reported. A review of serious incident reports indicate allegations received verbally and through the youth grievance system were reported by staff members to the IRC maintained by the OIG. Youth articulated understanding of the various reporting options, but not all said they would be able to report anonymously or privately.

(d): The facility provides youth access to the tools necessary to make a written report. Grievance forms are available in the common areas on the dorms. Youth may drop the completed grievance into one of several locked boxes located in dorms and in common campus areas. The TJJD OIG and OIO phone numbers are posted throughout the facility. Youth and staff interviews support compliance with this subsection. A youth who reported a sexual incident involving another youth touching her buttocks said she had everything she needed to write the report and that she did not need a staff member's assistance to write it.

(e): TJJD provides staff members the same reporting options as youth, but staff members' responses about reporting anonymously were inconsistent.

Recommendation: Since not all staff members and youth understood this right, reaffirm with the youth the OIO is a reporting source, provide additional training about the procedures for making private and/or anonymous reports.

Corrective Action: None

Standard 115.352 Exhaustion of administrative remedies

☐ Exceeds Standard (substantially exceeds requirement of standard)

☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

(a) – (g): The facility is exempt from this standard, as ERJC does not have administrative procedures to

address grievances regarding allegations of sexual abuse.

Standard 115.353 Resident access to outside confidential support services

- ☐ Exceeds Standard (substantially exceeds requirement of standard)
- ☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does Not Meet Standard (requires corrective action)

Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Documentation and Policy Reviewed:

1. GAP 380.9337 (i)(3)(A), (C)
2. MOU for The Women's Shelter of South Texas (WSST- (a local sexual assault shelter)
3. TJJD Youth Handbook

Interviews:

1. Youth
2. Staff Interviews

(a): TJJD policy requires that youth have access to outside victim advocates for emotional support services related to sexual abuse by making available mailing addresses and telephone numbers. An agreement (MOU) was established with the Women's Shelter of South Texas (WSST) to provide services, but the service had not been utilized in the past 12 months. Per the MOU, the WSST phone number is provided once it has been determined that the youth in question is the victim of sexual abuse and has refused on-site counseling services offered by TJJD. The phone number for the WSST was not found to be posted in obvious locations for youth to see. During interviews, the majority of youth were not aware of this or any outside service.

(b): TJJD policy requires that youth are informed, prior to giving them access, of the extent to which communications with outside services related to sexual abuse will be monitored and mandatorily reported. During interviews, staff members communicated understanding of mandatory reporting laws. Since youth lacked understanding of outside support services, they lacked understanding of the limits of confidentiality.

(c): An MOU with The WSST indicated an agreement was established to provide services. The service had not been used in the past 12 months by any youth at ERJC.

(d): TJJD policy requires reasonable and confidential access to youths' attorneys and parents or legal guardians. During interviews, youth said they received this access.

Corrective Action: Yes

1. Provide additional education to youth to make them aware that outside, independent victim advocates are available for emotional support services related to sexual abuse. Provide the auditors with documentation that these educational sessions were conducted. Additional interviews will be conducted with youth during the corrective action period. At a mimimum the WSST phone should be posted in the case manager's offices and administrative offices.

Corrective Action since the Audit::

1. During the follow up on site visits June 20th and November 16th, 2017 the Shelter's phone number was found posted in case manager's and mental health provider's offices across campus. Youth interviewed on November 16th confirmed they had knowledge of outside resources for additional counseling and support.

Standard 115.354 Third-party reporting

- ☐ Exceeds Standard (substantially exceeds requirement of standard)
- ☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does Not Meet Standard (requires corrective action)

Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Documentation and Policy Reviewed:

1. GAP 380.9337 (i)
2. Memo from the Superintendent regarding third party reporting to the OIO
3. TJJD website

(a): The TJJD website informs readers about reporting options. The primary referral option is through the IRC maintained by the OIG, but reports may also be made to the OIO, law enforcement agencies, Children's Protective Services, and to the facility directly.

Corrective Action: None

Standard 115.361 Staff and agency reporting duties

- ☐ Exceeds Standard (substantially exceeds requirement of standard)
- ☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does Not Meet Standard (requires corrective action)

Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Documentation and Policy Reviewed:

1. Completed PAQ
2. Employee Handbook
3. Memo from Superintendent regarding Staff and Agency Reporting Duties
4. GAP 380.9337(j) (1) (A-F)

Interviews:

1. Superintendent
2. Compliance Officer
3. PREA Compliance Director (TJJD Central Office Interview)
4. Nurse
5. Random staff

(a): TJJD policy requires that staff members must immediately report to the OIG any knowledge, suspicion, or information received regarding an incident of sexual abuse or sexual harassment. They are also required to report any incident of retaliation against youth or staff who reported such incidents and any staff neglect or violation of responsibilities that may have contributed to such an incident. This policy applies to any facility, whether or not it is operated by TJJD. Interviews with staff demonstrated their knowledge of their reporting responsibilities under Texas law, facility policy, and PREA regulations.

(b): TJJD policy requires that all staff members must comply with mandatory child abuse reporting laws in Texas Family Code and with applicable professional licensure requirements. Interviews with staff indicate they are aware and understand mandatory reporting laws.

(c): TJJD policy requires that all staff members who receive a report of alleged sexual abuse is prohibited from revealing that information to anyone other than to the extent necessary. Interviews with staff demonstrated they understand the requirements for sensitive youth information. They said they received the information during new hire and annual training and during dorm reviews.

(d): TJJD policy requires medical, mental health staff, clergy and attorneys whose communications may otherwise be privileged to report abuse as required by law and to inform youth of the limitations of confidentiality. Interviews with medical and mental health care staff confirm compliance with this standard relating to protection of confidential information and required disclosures.

(e): TJJD policy requires that the facility administrator must promptly report any allegation of alleged sexual abuse to the parents or legal guardians. If the alleged victim is under the conservatorship of DFPS, the report is made to DFPS. Four parent notification letters of the opening and closing of investigations were reviewed to support compliance with this subsection.

(f): TJJD policy requires that all staff members must immediately report all allegations of sexual abuse and sexual harassment to the OIG. OIG assigns all reports of alleged sexual abuse and sexual harassment, including third-party and anonymous reports, to the appropriate investigator. Interviews with the OIG investigator and the Superintendent confirmed this is the practice. They stated that all reports are submitted to the IRC, which is monitored by OIG. The auditors reviewed IRC documentation to confirm that allegations of sexual abuse or harassment were reported to the agency's department.

Corrective Action: None

Standard 115.362 Agency protection duties

- ☐ Exceeds Standard (substantially exceeds requirement of standard)
- ☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does Not Meet Standard (requires corrective action)

Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Documents and Policy Reviewed:

1. Completed PAQ
2. GAP 380.9337 (j) Relevant Documentation and Forms
3. Memo from Superintendent stating that the facility has not had a resident subject to a substantial risk of imminent sexual abuse in the 12 month period prior to the audit.

Interviews:

1. Superintendent
2. PREA Compliance Director (TJJD Central Office Interview)
3. Random staff

(a): TJJD policy requires that upon receipt of an allegation that a youth is subject to a substantial risk of imminent sexual abuse, TJJD must take immediate action to protect the youth. The agency reports that there have been no instances of this in the past 12 months. All staff members interviewed were able to explain precautions that would be taken to protect a youth at risk of imminent sexual abuse.

Corrective Action: None

Standard 115.363 Reporting to other confinement facilities

- ☐ Exceeds Standard (substantially exceeds requirement of standard)
- ☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does Not Meet Standard (requires corrective action)

Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Documents and Policy Reviewed:

1. Completed PAQ
2. GAP 380.9337 (j)
3. GAP 380.9337 (k)(1)
4. Memo from Superintendent stating no allegations of sexual abuse when they were confined at other facilities were made by any residents at Evins in the 12 months prior to the audit.

Interviews:

1. Superintendent
2. Compliance Officer
3. Executive Director (TJJD Central Office Interview)

(a): TJJD policy requires that any staff member who receives an allegation that a youth was sexually abused while confined at another facility must immediately notify the OIG, and the OIG must notify the head of the facility where the abuse occurred. The facility reports there have been no allegations of this type received in the past 12 months, and no notifications from other facilities in the past 12 months were received. The auditor's interview with the TJJD Executive Director prior to the on site audit confirmed knowledge of this requirement.

(b): TJJD policy requires that the notification will be provided as soon as possible, but no later than 72 hours after receiving the allegation.

(c): No allegations were received; therefore, no notifications were provided.

(d): TJJD policy does not contain the TJJD's guidelines requiring that allegations received from other facilities/agencies are investigated in accordance with the PREA standards and are the responsibility of the facility where the alleged abuse occurred

Corrective Action: Yes

1. Implement policy that contains the requirement that allegations received from other facilities/agencies are investigated in accordance with the PREA standards and are the responsibility of the facility where the alleged abuse occurred.

Corrective Action since the Audit:

1. Although policy does not contain the TJJD's guidelines requiring that allegations received from other facilities/agencies are investigated in accordance with the PREA standards and are the responsibility of the facility where the alleged abuse occurred, documentation was provided that illustrates compliance with this standard. The documentation includes notice from out-of-state facilities (adult & juvenile) sent to TJJD's PREA Compliance Director, the incident narrative, names of the alleged victim and offender, facility name, and TJJD investigative findings if any.

Standard 115.364 Staff first responder duties

☐ Exceeds Standard (substantially exceeds requirement of standard)

☐ Meets Standard (substantial compliance; complies in all material ways with the standard for the

relevant review period)

☒ Does Not Meet Standard (requires corrective action)

Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Documents and Policy Reviewed:

1. Completed PAQ
2. GAP 380.9337 (j)
3. Minutes and sign-in sheets from Dorm and Town Hall Meetings
4. Memo from Superintendent detailing First Responder Duties
5. Memo from Superintendent stating there were no youth allegations of sexual abuse in the 12 months prior to the audit.

Interviews:

1. Security staff and non-security staff first responders
2. Youth who reported a sexual abuse
3. Random staff

(a): TJJD policy contains all of the required elements of the first responder duties outlined in this standard. Interviews with staff members indicate an understanding of their first responder duties, and most were able to describe the procedures that would be followed to protect the youth and the crime scene. The following table represents totals for this standard reported by AID, OIG, and the facility on their respective PAQs.

Reporting Entity	Number of Allegations Received 115.322	Resulting Administrative Investigations 115.322	Referred for Criminal Investigation 115.322	Were all investigations completed? 115.322	Number of Grievances Filed 115.352	Completed within 90 Days 115.352	Number of Allegations 115.364	Notified within Timeframe for Evidence Collection 115.364	Number of Criminal/Administrative Investigations 115.373	Of the Completed Investigations, Number of Youth Notifications 115.373
Facility	Not answered								Not answered	11
AID	17	17	unknown	no	Not filled in	16	17	Not included in AID PAQ		
OIG	25	Unknown	25	yes	Not filled in	25	25	Not included in OIG PAQ		

(b): TJJD policy outlines the actions to be taken by the first staff member who learns of an allegation that a youth was sexually abused, but does not distinguish the first responder duties for security staff versus non-security staff.

Corrective Action: Yes

1. Based on this standard, a first responder must notify a security staff. Policy does not specify who is a first responder and who is considered a security staff member. Clarify in policy who holds these designations.

2. Provide an explanation of the discrepancy in the total number of allegations and investigations reported by the facility, AID, and OIG. (Reference 115.322)

Corrective Action since the Audit:

1. Although no revisions were made to policy, the PREA Compliance Director provided the following additions and revisions to the facility Written Coordinated Response.

- List of staff members who are considered first responders to include any staff member at the facility
- The option of notifying a JCO rather than notifying the on-duty supervisor or administrative duty officer immediately following a PREA-related allegation or incident
- Identified the on-duty supervisor as the JCO VI
- Clarified that a JCO or non-JCO must follow the same procedures such as separating the alleged victim and preserving the scene as the on-duty supervisor and administrative duty officer immediately following a PREA-related allegation or incident

The auditor interviewed three JCOs, one dorm supervisor, and one non-JCO staff member. All understood and articulated their first responder duties, which included separating the alleged victim and abuser, protecting the area, and notifying supervisory staff.

2. The remaining 1 investigation had not concluded within the audit period but was within the 90-day closure requirement. No investigations were delinquent or incomplete.

The OIG Inspector General provided a memorandum explaining the discrepancies in the table above. Each state the reasons for the different totals include:

- There are three or more agency divisions which may receive reports or allegations
- The divisions may properly or improperly classify incidents as PREA-related based on their assessment of the incident.
- Facility staff may over or incorrectly report.
- AID and OIG correct erroneously classified reports. For example, the facility classifies an incident as a PREA incident and after further investigation; the AID or OIG reclassifies the incident as non-PREA. This results in discrepancies in the total number of PREA-related incidents reported by each entity.
- Since youth may report directly to AID or OIG, the facility would not have a record of those incidents until the final PREA report was given to the Superintendent for the Sexual Assault Review Board.

The opening of investigations may begin prior to or during the audit but not close until after the audit period concludes.

Standard 115.365 Coordinated response

☐ Exceeds Standard (substantially exceeds requirement of standard)

☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Documents and Policy Reviewed:

1. Completed PAQ
2. GAP 380.9337 (j)
3. Evins Coordinated Response Plan
4. Memo from Superintendent detailing first responder Duties

Interviews:

1. Superintendent
2. PREA Compliance Director

(a): The facility maintains a written institutional plan to coordinate responses to allegations of sexual abuse. The plan includes procedures for first responders, on-duty supervisors, medical and mental health care staff, investigators, facility leadership, sexual abuse review board members, and the Compliance Officer. The duties outlined in the plan require the first responder to notify the on-duty supervisor, notify infirmary staff, and report the allegation to the IRC and chief local administrator. The on-duty supervisor is responsible for separating the alleged perpetrator and alleged victim and securing the crime scene. The actions outlined in GAP 380.9337 (j) require the first responder to separate the alleged victim and alleged abuser, preserve the crime scene, and take additional actions if the allege abuse occurs within a timeframe that allows for the collection of physical evidence. The Institutional Operations Manual (INS 71.01) requires actions, which align with the written institutional plan.

Recommendation: Post the details of the facility's coordinated written response plan and meet annually with all entities to discuss the plan.

Corrective Action: Yes

1. Revise the written institutional plan, GAP, and/or INS to align first responder duties in each document.

Corrective Action since the Audit:

1. Although no revisions were made to policy, the PREA Compliance Director provided the following additions and revisions to the facility Written Coordinated Response.

- List of staff members who are considered first responders to include any staff member at the facility
- The option of notifying a JCO rather than notifying only the on-duty supervisor or administrative duty officer immediately following a PREA-related allegation or incident
- Identified the on-duty supervisor as the JCO VI
- Clarified that a JCO or non-JCO must follow the same procedures such as separating the alleged victim and preserving the scene as the on-duty supervisor and administrative duty officer immediately following a PREA-related allegation or incident

The auditor interviewed 10 JCOs and JCO Supervisors during on-site follow up. All staff members understood and articulated their first responder duties, which included separate the alleged victim and abuser, protect the area, and notify supervisory staff. The facility provided caard to all employees reminding them of First Responders duties for quick review.

Standard 115.366 Preservation of ability to protect residents from contact with abusers

- ☐ Exceeds Standard (substantially exceeds requirement of standard)
- ☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does Not Meet Standard (requires corrective action)

Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Documents and Policy Reviewed:

1. Completed PAQ

Interviews:

1. TJJD Executive Director (TJJD Central Office Interview)
2. PREA Compliance Director (TJJD Central Office Interview)

(a): TJJD meets the requirements of this subsection as TJJD does not enter into collective bargaining agreements that would limit TJJD's ability to remove alleged staff sexual abusers from contact with any youth pending an investigation determination.

(b): ERJC meets the requirements of this standard as the facility does not enter into collective bargaining agreements.

Corrective Action: None

Standard 115.367 Agency protection against retaliation

- ☐ Exceeds Standard (substantially exceeds requirement of standard)
- ☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does Not Meet Standard (requires corrective action)

Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Documents and Policy Reviewed:

1. Completed PAQ
2. GAP 380.9337 (j)
3. Documentation of monitoring retaliation
4. Agency PREA Monitoring Form

Interviews:

1. TJJD Executive Director (TJJD Central Office Interview)
2. Superintendent
3. PREA Compliance Director (TJJD Central Office Interview)
4. Staff who monitor for retaliation
5. Youth who reported a sexual abuse

(a): TJJD policy prohibits retaliation by a youth or staff member against a youth or staff member who reports or cooperates with an investigation. Certain staff members are designated to monitor the person who reported the allegation and the alleged victim for possible retaliation. The facility reports that there have been no incidents of retaliation that have occurred in the past 12 months.

(b): The TJJD uses multiple protection measures to protect youth and staff from retaliation, such as housing transfers, transfers of youth, removal of alleged abuser from contact with the alleged abuser, and emotional support services. The auditors reviewed completed monitoring forms to support compliance with this standard. Staff members were able to articulate actions utilized to protect youth and staff members and monitor for retaliation. The Superintendent said measures could include dorm transfers, bed assignment changes, implementing boundary plans, utilizing the monitoring form, or reporting suspected retaliation to the IRC.

(c): TJJD policy requires the agency to continue monitoring for retaliation for at least 90 days following a report, except when the allegation is determined to be unfounded. An extension is possible beyond 90 days if needed. Administrators and the staff member responsible for monitoring were knowledgeable about the duty to monitor for retaliation for at least 90 days. They said this time would be extended if needed as there is no maximum time for monitoring efforts. Completed monitoring forms indicated compliance with the 90-day timeline.

(d): TJJD policy requires that staff members conduct periodic status checks of the alleged victim. The staff member responsible for monitoring for retaliation stated there is no maximum length of time a youth would be monitored.

(e): TJJD policy requires that staff take appropriate measures to protect any other individual who cooperates with the investigation who may be at risk of retaliation or who expresses a fear of retaliation. Completed monitoring forms evidenced protection measures taken by ERJC.

(f): TJJD policy requires that the agency's obligation to monitor shall terminate if the investigation determines the allegation is unfounded.

Recommendation: Review on a routine basis the monitoring requirements with the staff who are responsible for monitoring to ensure they remain alert to the requirements.

Corrective Action: None

Standard 115.368 Post-allegation protective custody

- ☐ Exceeds Standard (substantially exceeds requirement of standard)
- ☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does Not Meet Standard (requires corrective action)

Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Documentation and Policy Reviewed:

1. Completed PAQ
2. GAP 380.9337 (j)
3. Memorandum from Superintendent documenting the facility's no isolation policy
4. INS.71.01

Interviews:

1. Superintendent
2. Staff who supervise youth
3. Medical and mental health care staff

(a): TJJD policy prohibits using segregated housing to protect a youth who is alleged to have suffered sexual abuse. Staff interviews indicated that isolation is not used to protect youth who have alleged to suffer a sexual abuse.

Corrective Action: None

Standard 115.371 Criminal and administrative agency investigations

- ☐ Exceeds Standard (substantially exceeds requirement of standard)
- ☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does Not Meet Standard (requires corrective action)

Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Documentation and Policy Reviewed:

1. Completed PAQ
2. GAP 380.9337 (k)
3. Investigative records
4. Substantiated and unsubstantiated investigative records
5. Training records for investigators
6. Lesson Plans Titled "Conducting Quality Investigations"
7. PowerPoint Training on "Conducting Quality Investigations"

Interviews:

1. Superintendent
2. Random staff
3. Investigators
4. Youth who have reported a sexual abuse/harassment

(a): TJJD policy requires that investigations will be conducted promptly, thoroughly and objectively for all allegations, including third party and anonymous reports. Interviews with investigators demonstrated understanding of and compliance with this standard. Five (5) AID and three (3) OIG, investigative reports were provided and reviewed by the auditors. Each appear thorough and include a summary, preliminary findings, case detail including each action taken during the investigation, victims, witnesses, suspects, physical evidence, and investigative results.

(b): TJJD policy requires that it will use investigators who have received special training in sexual abuse investigations involving juvenile victims per Standard 115.334. All investigators have received certifications for completed training from the National Institute of Corrections (NIC). Investigators interviewed confirmed their understanding of interviewing youth, evidence collection in confinement settings, and criteria needed to substantiate a case.

(c): TJJD policy requires that investigators gather and preserve direct and circumstantial evidence, including any available physical and DNA evidence. They will include any available electronic monitoring data, interview appropriate persons, and review prior complaints involving the alleged perpetrator. Interviews with investigative staff demonstrate knowledge of conducting investigations of this type. The AID and OIG investigative reports include preliminary findings and determinations of resulting full investigations, evidence collected such as interviews with staff members and youth, video and document review, and outcome decisions. The State of Texas Retention Schedule for TJJD investigative files states that AID files are retained for five years after the case is closed. OIG criminal investigative files are retained for 20 – 50 years depending on the type of case.

(d): TJJD policy requires that investigations will not be terminated because the source of the allegation recants the allegation. The investigators supported compliance with this standard stating that an investigation would not end due to an allegation being recanted.

(e): TJJD policy requires that when the evidence supports criminal prosecution, compelled interviews may be used, but only after consulting with prosecutors as to whether compelled interviews may be an obstacle for subsequent criminal prosecution. Both investigators stated OIG would conduct compelled interviews only if there was sufficient evidence to do so. The OIG investigative report did not indicate compelled interviews took place.

(f): TJJD policy requires investigators to assess the credibility of an alleged victim, suspect, or witness on an individual basis and not on the person's status as a youth or staff. The policy states they do not require youth who allege sexual abuse to submit to a polygraph or other truth-telling device as a condition for proceeding with the investigation. Interviews with investigators confirmed understanding of and compliance with this practice.

(g): TJJD policy requires that administrative investigations include an effort to determine whether staff actions or failures to act contributed to the abuse. Additionally, policy requires that investigators document the investigation in written reports that include descriptions of the evidence, the reasoning behind credibility assessments, and investigative facts and findings. The AID investigative report indicates evidence including video and witness statements was analyzed when considering whether the actions of the staff member contributed to the abuse. The preliminary findings state a full investigation was warranted after considering all evidence.

(h): TJJD policy requires criminal investigations conducted by OIG to be documented in a written report that includes the evidence and attach copies of documentary evidence where possible. The AID and OIG investigative reports include preliminary findings and determinations of resulting full investigations, evidence collected such as interviews with staff members and youth, video and document review, and outcome decisions. Physical and documentary evidence was not provided but was listed within the report.

(i): TJJD policy requires that substantiated allegations of conduct that appear to be criminal are referred for prosecution. The OIG PAQ states that there was one (1) substantiated allegations of conduct that appear to be criminal that was referred for prosecution since the last PREA audit.

(j): TJJD policy requires the agency to retain all written administrative investigative reports for as long as the alleged abuser is incarcerated or employed by the agency, plus five years. While this timeframe aligns with The State of Texas Retention Schedule for TJJD administrative investigative files, it does not align with the retention timeframe for criminal investigative files, which requires files to be retained for 20 – 50 years depending on the type of case. The auditors recommend aligning GAP with The State of Texas Retention Schedule for criminal cases.

(k): TJJD does not terminate investigations solely on the basis that the alleged abuser or victim is no longer with the agency. The investigative staff said the investigation would continue regardless if the alleged abuser or victim is no longer employed or placed at ERJC.

(l): TJJD OIG follows the above standards.

(m): TJJD policy requires that staff members cooperate with outside agencies that conduct investigations and remain informed about the progress of the investigations. During interviews, the Superintendent and investigators said that outside agencies are not used for investigations. The OIG investigator said that no outside agency has conducted an investigation since his employment but if one were used, he would act as a liaison between the investigative agency and the ERJC.

Recommendation: The auditors recommend aligning GAP with The State of Texas Retention Schedule for criminal cases.

Corrective Action: None

Standard 115.372 Evidentiary standard for administrative investigations

- ☐ Exceeds Standard (substantially exceeds requirement of standard)
- ☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does Not Meet Standard (requires corrective action)

Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Documentation and Policy Reviewed:

1. Completed PAQ
2. GAP 380.9337 (k)(2)
3. Sample investigation reports

Interviews:

1. Superintendent
2. Administrative Investigator

(a): TJJD policy requires that standard of proof used by the agency in administrative investigations is a preponderance of the evidence. The interview with the facility investigator confirmed knowledge of the required standard of proof and that his practice was to use "preponderance of the evidence" in investigations.

Corrective Action: None

Standard 115.373 Reporting to residents

- ☐ Exceeds Standard (substantially exceeds requirement of standard)
- ☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does Not Meet Standard (requires corrective action)

Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Documentation and Policy Reviewed:

1. Completed PAQ
2. GAP 380.9337 (k)
3. Youth notifications spreadsheet

Interviews:

1. Superintendent
2. Investigative staff
3. Youth who reported sexual abuse

(a): TJJD policy requires that until the youth is discharged from TJJD, the facility will inform the youth whether the allegation is substantiated, unsubstantiated, or unfounded. Interviews with investigative staff corroborate this is the practice. Although number of investigations reported and notifications documented ddo not match.

Reporting Entity	Number of Allegations Received 115.322	Resulting Administrative Investigations 115.322	Referred for Criminal Investigation 115.322	Were all investigations completed? 115.322	Number of Grievances Filed 115.352	Completed within 90 Days 115.352	Number of Allegations 115.364	Notified within Timeframe for Evidence Collection 115.364	Number of Criminal/Administrative Investigations 115.373	Of the Completed Investigations, Number of Youth Notifications 115.373
Facility										11
AID	17	17	Unknown	No		16	17	Not included in AID PAQ		
OIG	25	Unknown	25	yes		25	25	Not included in OIG PAQ	36	18

(b): This subsection does not apply; the agency is responsible for conducting administrative and criminal investigations.

(c): TJJD policy requires that youth are notified when 1) the staff member is no longer posted within the youth's unit, 2) the staff member is no longer employed at the facility, 3) when the staff member has been indicted, or 4) when the staff member has been convicted on a charge related to sexual abuse within the facility. The AID investigative staff member and the Superintendent said youth and parent notification is the responsibility of the Superintendent.

(d): TJJD policy requires that following a youth's allegation that he or she was sexually abused by another youth, TJJD informs the youth when 1) the abuser has been indicted, or 2) the abuser has been convicted on a charge related to sexual abuse.

(e): TJJD policy does not require documentation on all such notifications or attempted notifications under this standard. Documentation that tracked all notifications was not available for review.

(f): TJJD policy requires that the notification obligations of this standard apply until the youth is discharged from TJJD.

Corrective Action: Yes

1. Provide an explanation of the discrepancy in the total number of allegations, investigations, and notifications reported by the facility, AID, and OIG.

2. Include in policy and develop a process for documenting all notifications and attempted notifications. Provide evidence that the documentation has been implemented.

Corrective Action since the Audit:

The remaining 1 investigation had not concluded within the audit period but was within the 90-day closure requirement. No investigations were delinquent or incomplete.

The OIG Inspector General provided a memorandum explaining the discrepancies in the table above. Each state the reasons for the different totals include:

- There are three or more agency divisions which may receive reports or allegations
- The divisions may properly or improperly classify incidents as PREA-related based on their assessment of the incident.
- Facility staff may over or incorrectly report.
- AID and OIG correct erroneously classified reports. For example, the facility classifies an incident as a PREA incident and after further investigation; the AID or OIG reclassifies the incident as non-PREA. This results in discrepancies in the total number of PREA-related incidents reported by each entity.
- Since youth may report directly to AID or OIG, the facility would not have a record of those incidents until the final PREA report was given to the Superintendent for the Sexual Assault Review Board.
- The opening of investigations may begin prior to or during the audit but not close until after the audit period concludes.

The Compliance Director provided the new document to be used by all TJJD facilities to capture the information required for the youth notification process, which includes youths' names, identification number, date the youth was indicted/prosecuted, investigation initiation and closure dates, and dates the staff was removed from the dorm or halfway house, terminated, and indicted/prosecuted. Samples of completed spreadsheets illustrate the new document is being utilized by the facility.

Standard 115.376 Disciplinary sanctions for staff

☐ Exceeds Standard (substantially exceeds requirement of standard)

☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Documentation and Policy Reviewed:

1. Completed PAQ

2. GAP 380.9337 (l)
3. Memorandum from Superintendent documenting zero terminations
4. Memorandum from Superintendent documenting one resignation
5. Staff disciplinary sanctions
6. Employee Handbook

(a): TJJD policy requires that staff members who violate the agency's sexual abuse or sexual harassment policies are subject to disciplinary sanctions up to and including termination.

(b): TJJD policy requires that termination of employment is the presumptive disciplinary sanction for staff members who have engaged in sexual abuse. This information is also included in the Employee Handbook. In the past 12 months, the facility reports that no staff member has violated the TJJD sexual abuse or sexual harassment policy, or resigned following a PREA-related conduct.

(c): TJJD policy requires that disciplinary sanctions will be commensurate with the nature and circumstances of the acts committed, the staff member's disciplinary history, and the sanctions imposed for comparable offenses by other staff with similar histories. The facility reports zero instances of staff members being reported to law enforcement or licensing bodies following a termination or resignation prior to termination.
(d): TJJD policy requires reporting the following actions to licensing bodies 1) terminations of employment for violations of TJJD sexual abuse or sexual harassment policies, and 2) resignations by staff members who would have been terminated if they had not resigned. No staff members were terminated for PREA-related conduct.

Corrective Action: None

Standard 115.377 Corrective action for contractors and volunteers

- ☐ Exceeds Standard (substantially exceeds requirement of standard)
- ☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does Not Meet Standard (requires corrective action)

Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Documentation and Policy Reviewed:
1. Completed PAQ
2. GAP 380.9337 (l)
3. Memorandum from Superintendent documenting zero allegations or reprimands

Interviews:
1. Superintendent

(a): TJJD policy requires that if a contractor or volunteer engages in sexual abuse, TJJD prohibits the

contractor or volunteer from having contact with youth and shall report the finding of abuse to relevant licensing bodies. In the past 12 months, the facility reports that no contractors or volunteers have been reported to the OIG for engaging in sexual abuse of youth. The interview with the Superintendent confirms her knowledge of this requirement.

(b): TJJD policy requires that if a volunteer or contractor violates sexual abuse or sexual harassment policy, but does not actually engage in sexual abuse, TJJD will take appropriate remedial measures and considers whether to prohibit further contact. The facility reported no cases of a volunteer or contractor who was disciplined for policy violation.

Corrective Action: None

Standard 115.378 Disciplinary sanctions for residents

- ☐ Exceeds Standard (substantially exceeds requirement of standard)
- ☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does Not Meet Standard (requires corrective action)

Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Documentation and Policy Reviewed:

1. Completed PAQ
2. GAP 380.9337 (l)
3. Memorandum from Superintendent documenting zero disciplinary actions for youth alleging abuse

Interviews:

1. Superintendent
2. Medical and mental health staff

(a): TJJD policy requires that a youth may be subject to disciplinary sanctions only after a substantiated finding in an administrative investigation or a criminal finding that a youth participated in the sexual abuse of another youth or staff member. The facility reports there have been no administrative or criminal findings regarding youth-on-youth sexual abuse occurring in the facility in the past 12 months. The interview with the Superintendent confirmed her knowledge of the requirements of this standard related to youth discipline.

(b): TJJD policy requires that any disciplinary sanctions must be commensurate with the nature and circumstances of the abuse committed, the youth's disciplinary history, and the sanctions imposed for comparable offenses by other youth with similar histories. Discipline is determined through a Level II due process hearing held in accordance with GAP 380.9555. The Superintendent said sanctions could include

placement in the Redirect Program (a more restrictive program within ERJC) or loss of privileges. The facility reports that in the past 12 months there have been no youth placed in isolation as a disciplinary sanction for youth-on-youth sexual abuse.

(c): TJJD policy requires that the disciplinary process consider whether a youth's mental disability or mental illness contributed to his or her behavior. The interview with the Superintendent and medical and mental health care staff indicated this is the practice when determining youth sanctions.

(d): TJJD policy requires that the facility offer counseling and other interventions designed to address and correct underlying reasons or motivations for the abuse. TJJD may require participation as a condition of access to behavior-based incentives, but not as a condition to access general programming or education. Medical and mental health care staff members said counseling and therapy is offered to youth offenders and victims.

(e): TJJD policy requires that a youth may be disciplined for sexual contact with staff only upon a finding that the staff did not consent to such contact. This is preceded by a criminal investigation by OIG.

(f): TJJD policy requires that a youth may not be disciplined if the youth made a report of sexual abuse in good faith based upon a reasonable belief that the alleged conduct occurred, even if an investigation does not establish evidence sufficient to substantiate the allegation.

(g): TJJD policy prohibits all sexual activity between youth and may discipline a youth in accordance with GAP 380.9503 for engaging in sexual activity that meets the definition of abuse. Regardless of the conduct, all sexual misbehaviors are included in the agency data collection.

Corrective Action: None

Standard 115.381 Medical and mental health screenings; history of sexual abuse

- ☐ Exceeds Standard (substantially exceeds requirement of standard)
- ☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does Not Meet Standard (requires corrective action)

Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Documentation and Policy Reviewed:

1. Completed PAQ
2. GAP 380.9337 (m)
3. Intake screenings

Interviews:

1. Medical and mental health care staff
2. Youth who reported a sexual abuse during screening

(a): TJJD policy requires that regardless of the intake screening results, the facility shall offer all youth, including youth offenders, a follow-up meeting with medical or mental health practitioners within 14 days of the intake screening. Youth interviews indicated follow-up medical and mental health care is offered. Interviews with staff who conduct the screening indicate that trauma counseling is provided to youth in need of these services within 24 hours or as soon as possible. Psychological assessments, treatment notes, and resulting mental health services such as trauma counseling, mental health treatment, and sexual behavior treatment showed that these services occurred within 14 days for those youth identified as needing these services.

(b): TJJD policy requires that any information obtained related to sexual victimization or abusiveness that occurred in an institutional setting must be strictly limited to medical and mental health practitioners and other staff, as necessary, to inform treatment plans and security and management decisions including housing, bed, work, education and program assignments, or the facility. Interviews with staff responsible for the screening indicate that follow-up services are provided within 24 hours or as soon as possible. Secondary materials are discussed in the above subsection.

(c): Youth files are stored in a secure location, which was observed during the facility inspection. Limited staff members have access to these files. Medical information is storedin the infirmary in the Electronic Medical Records system through University of Texas Medical Branch, which also has limited access.

(d): TJJD policy requires that staff members must obtain informed consent from youth age 18 or over before reporting information about prior sexual victimization that did not occur in an institutional setting. Interviews with mental health staff indicate that informed consent is obtained.

Corrective Action: None

Standard 115.382 Access to emergency medical and mental health services

☐ Exceeds Standard (substantially exceeds requirement of standard)

☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Documentation and Policy Reviewed:

1. Completed PAQ
2. Interagency Cooperation Agreement with UTMB
3. Nursing Assessment Protocols
4. PREA Protocols

Interviews:

1. Medical and mental health care staff
2. Youth who reported a sexual abuse
3. Staff who conduct risk assessments

(a): TJJD policy requires that youth victims of sexual abuse shall receive timely unimpeded access to emergency medical treatment and crisis intervention services, the nature and scope of which are determined by medical and mental health practitioners per their professional judgment. Interviews with medical and mental health staff confirm this is the practice. Medical and mental health care staff said all youth received these services and when emergency medical treatment is required, youth are transported to the community hospital.

(b): TJJD policy requires that if no qualified medical or mental health practitioners are on duty at the time of a report of recent abuse is made, staff first responders must take preliminary steps to protect the victim pursuant to Standard 115.362 and shall immediately notify the appropriate medical and mental health practitioners. Interviews with staff demonstrate their knowledge of first responder protocols and procedures for acute cases of sexual abuse. The ERJC Coordinated Response to Allegations of Sexual Abuse includes the notification of medical and mental health care staff as a first responder duty.

(c): TJJD policy requires that the facility offers youth victims of sexual abuse timely information about and timely access to emergency contraception and sexually transmitted infection prophylaxis, in accordance with professionally accepted standards of care, and where medically appropriate. Interviews with medical staff confirm that this would occur at the local hospital where the youth would be transported for the SANE exam.

(d): TJJD policy requires that the facility shall offer these treatment services to the victim without financial cost and regardless of whether the victim names the abuser or cooperates with any investigation arising out of the incident. Interviews corroborated that victims are not charged for these treatment services.

Corrective Action: None

Standard 115.383 Ongoing medical and mental health care for sexual abuse victims and abusers

☐ Exceeds Standard (substantially exceeds requirement of standard)

☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Documentation and Policy Reviewed:

1. Completed PAQ
2. GAP 380.9337 (m)
3. Memo from the facility Health Services Administrator regarding medical and mental

health evaluations for victims of sexual abuse. 115.383(a)
4. Memo from the facility Health Services Administrator regarding medical and mental health services being consistent with the community level of care. 115.383(c)
5. Memo from the facility Health Services Administrator regarding pregnancy testing. 115.383(d)
6. Memo from the facility Health Services Administrator regarding the opportunity for sexually transmitted diseases to victims of sexual abuse. 115.383(f)

Interviews:

1. Medical and mental health care staff
2. Youth who reported a sexual abuse
3. Staff who conduct risk assessments

(a): TJJD offers medical and mental health evaluations and, as appropriate, treatment to all youth who are victims of sexual abuse in any facility. Interviews with medical and mental health staff indicated all youth undergo a screening during intake and periodically throughout their stay and receive follow-up services as needed. The auditors reviewed psychological assessments to ensure documentation of initial and on-going medical and mental health care services.

(b): TJJD policy requires that the evaluation and treatment of victims include follow-up services, treatment plans, and referrals for continued care following a youth's transfer to other facilities or release from custody. Medical and mental health care staff members said counseling and therapy is offered to youth offenders and victims.

(c): During interviews, medical and mental health care staff reported the level of care received at ERJC through on-site psychology and the University of Texas Medical Branch is consistent with the community level of care.

(d): TJJD policy requires that pregnancy tests are offered to youth victims of sexually abusive vaginal penetration that occurs while they are incarcerated at a TJJD facility. This would not apply to ERJC as it is an all male facility.

(e): TJJD policy requires that if pregnancy results from a sexual assault, the youth is provided timely and comprehensive information about and timely access to all lawful pregnancy-related medical services. Additional services provided to youth are included in GAP 380.9195.

(f): TJJD policy requires TJJD to offer tests for sexually transmitted infections, as medically appropriate, to youth victims of sexual abuse while incarcerated.

(g): TJJD policy requires that all treatment services are provided to the victim without financial cost and regardless of whether the victim names the abuser or cooperates with any investigation arising out of the incident.

(h): TJJD policy requires that TJJD attempts to conduct a mental health evaluation of all known youth-on-youth abusers within 60 days of learning of such abuse history and shall offer treatment when deemed appropriate by mental health care staff. Medical and mental health staff members reported that all youth receive a mental health evaluation during intake and periodically throughout their stay.

Corrective Action: None

Standard 115.386 Sexual abuse incident reviews

- ☐ Exceeds Standard (substantially exceeds requirement of standard)
- ☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does Not Meet Standard (requires corrective action)

Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Documentation and Policy Reviewed:

1. Completed PAQ
2. GAP 380.9337 (n)
3. Sexual Abuse Review Board meetings 2016-2017
4. SARB members

Interviews:

1. Facility Superintendent
2. PREA Compliance Director (TJJD Central Office Interview)
3. Incident review team member

(a): TJJD policy requires ERJC to conduct a sexual abuse review board (SARB) at the conclusion of every sexual abuse investigation unless the allegation is determined to be unfounded. The team includes managers, supervisors, investigators, and medical and mental health practitioners. The team considers 1) whether the allegation or investigation indicates a need to change policy or practice, 2) whether the incident was motivated by race, ethnicity, gender identity, status or perceived status as LGBTI, gang affiliation, or was motivated or otherwise caused by other group dynamics at the facility motivated the incident, 3) physical barriers that may enable abuse, 4) staffing levels, and 5) whether monitoring technology should be enhanced. Policy requires that following the SARB, ERJC implement the review team's recommendations or reasons for not doing so.

The facility reports that in the past 12 months, there have been seven (7) SARBs conducted and 6 Notifications of No required Meeting. Interviews with facility administrators indicated their knowledge and understanding of the sexual abuse incident review process as required by this standard, and they corroborated this is the practice for all incidents of sexual abuse in the facility. Documentation of monthly SARBs was provided for those months in which SARBs occurred. SARB forms include discussion topics, which address each of the elements for subsection (a) above, minutes, members present, statement of finding, recommendations, and action plan. A memorandum stating that no SARB was conducted was provided for those months during which no SARB was warranted.

(b): TJJD policy does not require the review to occur within 30 days of the conclusion of the investigation;

however, the corresponding investigation and SARB reviewed supported compliance with this standard as the review occurred within 30 days of the closure of the investigation. Additionally, documentation confirms SARBs are conducted monthly.

(c): TJJD policy requires that managers, supervisors, investigators, and medical or mental health practitioners participate in the review. The auditors reviewed SARB reports to ensure these members were present during monthly SARB meetings.

(d): SARB forms include discussion topics, which address each of the elements for subsection (a) above, minutes, members present, statement of finding, recommendations, and action plan. Interviews with facility staff indicate that each element is considered and determinations documented. Minutes and completed forms support compliance with this standard.

(e): TJJD policy requires that the facility implement the SARB team's recommendations or document the reasons for not doing so. Action plans that were implemented included housing changes, placing the youth in the Redirect Program (a more restrictive program within ERJC), and staff reassignments. Interviews with the Compliance Officer and Superintendent corroborated the practice of implementing the action plans following a SARB.

Corrective Action: None

Standard 115.387 Data collection

- ☐ Exceeds Standard (substantially exceeds requirement of standard)
- ☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does Not Meet Standard (requires corrective action)

Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Documentation and Policy Reviewed:

1. Completed PAQ
2. GAP 380.9337 (o)
3. Copy of definitions
4. Data collection Instrument
5. Survey of Sexual Victimization, 2012, 2015)

Interviews:

1. Superintendent
2. PREA Compliance Director (TJJD Central Office Interview)

(a): TJJD policy requires that TJJD collect data for every allegation of sexual abuse at TJJD-operated facilities using a standardized instrument and set of definitions. TJJD also maintains, reviews, and collects data as needed from all available incident-based documents, such as reports, investigation files, and sexual abuse incident reviews. TJJD develops its data collection instrument to include the data necessary to answer all questions from the most recent version of the Survey of Sexual Violence conducted by the U.S. Department of Justice (DOJ).

(b): TJJD policy requires that TJJD aggregate the data at least once each year. The interview with the PREA Compliance Director corroborated that the data is collected once per year.

(d): TJJD policy requires that TJJD maintains, reviews, and collects data as needed from all available incident-based documents, such as reports, investigation files, and sexual abuse incident reviews.

(e): TJJD policy requires that TJJD obtain incident-based and aggregate data from each residential facility operating under a contract with TJJD. The auditors reviewed a screen shot from 2013 of the PREA Data Collection System to ensure the data is aggregated by each facility. During the interview the PREA Compliance Director, he stated that contract facilities are included in the data collection.

(f): TJJD policy does not require the agency to provide all such data from the previous calendar year to the DOJ no later than June 30, but a review of documentation indicates this is the regular practice, and the data is provided annually.

Corrective Action: None

Standard 115.388 Data review for corrective action

- ☐ Exceeds Standard (substantially exceeds requirement of standard)
- ☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does Not Meet Standard (requires corrective action)

Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Documentation and Policy Reviewed:

1. Completed PAQ
2. GAP 380.9337 (p)
3. Memorandum of PREA Sexual Misconduct Preventative Measures
4. Memorandum of annual review/corrective action plan from PREA Compliance Department

Interviews:

1. Superintendent
2. Executive Director (TJJD Central Office Interview)

3. PREA Compliance Director (TJJD Central Office Interview)
4. Compliance Officer

(a): TJJD policy requires that TJJD review aggregate sexual abuse data to assess and improve the effectiveness of its policies, practices, and training. Following this review, TJJD prepares an annual report of its findings and corrective actions for each facility and the agency as a whole. The TJJD Executive Director indicated his knowledge of the data review. The PREA Compliance Director said each facility prepares an annual corrective action plan based on the allegations explaining what actions they will take to further prevent, detect, and respond to allegations of sexual abuse and harassment. The ERJC preventative measures include reviewing cameras, opposite gender announcements when entering dorms, maintaining proper ratios, implementation of safety plans for high-risk youth, installation of new cameras in the security units, and reviewing the safe housing rosters.

(b): The auditors reviewed the memorandum provided by the PREA Compliance Director to ensure the review included a comparison of the previous year's sexual abuse data. The report compares the years 2015 and 2016. The memorandum includes each contract facility, TJJD facilities, and agency-wide current and future plans, corrective actions, and proactive steps taken to eliminate sexual abuse and harassment. The ERJC plan is discussed above in subsection (a).

(c): TJJD policy requires that TJJD post on its website all aggregated sexual abuse data from TJJD-operated and contracted facilities. Although policy does not require the Executive Director to approve the report, documentation of his approval was provided. The TJJD Director said the PREA Compliance Director completes the report and submits it for review.

(d): A review of the posted data indicates TTJD takes appropriate measures to redact specific material from the reports when publication would present a clear and specific threat to the safety and security of the facility. The PREA Compliance Director reported that all personal information on a perpetrator, victim, or witness is redacted from the annual report prior to submission of the report. He also stated that since the reports do not contain sensitive information, TJJD is not required to indicate the nature of the materials redacted.

Corrective Action: None

Standard 115.389 Data storage, publication, and destruction

- ☐ Exceeds Standard (substantially exceeds requirement of standard)
- ☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does Not Meet Standard (requires corrective action)

Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Documentation and Policy Reviewed:

1. Completed PAQ

2. GAP 380.9337 (o), (p)
3. Screenshot from the TJJD website showing links to reports containing the required aggregated data.
4. State of Texas Records Retention Schedule

Interviews:

1. Superintendent
2. PREA Compliance Director (TJJD Central Office Interview)

(a): TJJD policy requires that all sexual abuse data is securely retained. The PREA Compliance Director confirmed compliance and stated the data is password protected and only the PREA Compliance Director has access to the database. The data is derived from the OIG and AID databases and access to these are strictly limited. He sated the agency takes corrective action on an ongoing basis if the data reveals immediate actions need to be taken.

(b): TJJD policy requires that TJJD post on its website all aggregated sexual abuse data from TJJD-operated and contracted facilities. The auditors confirmed the data is included on the TJJD website.

(c): A review of the published data revealed TJJD removes all personal identifiers prior to making aggregated sexual abuse data publicly available.

(d): PREA Standard 115.389 requires TJJD to maintain sexual abuse data for at least 10 years after the date of its initial collection, unless Federal, State, or local law requires otherwise. Historical data is available on the website beginning in 2012, which supports compliance with this subsection.

Corrective Action: None

AUDITOR CERTIFICATION
I certify that:

☒ The contents of this report are accurate to the best of my knowledge.

☒ No conflict of interest exists with respect to my ability to conduct an audit of the agency under review, and

☒ I have not included in the final report any personally identifiable information (PII) about any inmate or staff member, except where the names of administrative personnel are specifically requested in the report template.

Allen E Wallace — 12 07 2017

Auditor Signature — Date